

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04183

4203

1. PLACE OF DEATH a. COUNTY <u>Lansdowne</u> <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1939 Victory Drive</u>				d. STREET ADDRESS <u>1939 Victory Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Elizabeth Adams</u>				4. DATE OF DEATH <u>April</u> Month <u>7</u> Day <u>58</u> Year <u>1958</u>			
5. SEX <u>Fem</u>		6. COLOR OR RACE <u>White</u>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 28, 1870</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Duties</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>George W. Adams</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Hancock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>210-01-2578A</u>		17. INFORMANT <u>Lois A. Lucas</u> Address <u>1939 Victory Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Acute cardiac failure.</u> DUE TO <u>Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c) <u>Senility</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>G. S. M. Kieffer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>G. S. M. Kieffer M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>	
22d. LOCATION (City, town, or county) <u>Balto., Md.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balto.</u>				ADDRESS <u>17th</u>		24a. REC'D BY REGISTRAR <u>APR 9 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. J. Tiekner</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 9 1958

RECEIVED

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No. 04185

VS A15 (4)
15M 9/55

RECEIVED

17
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4214 CERTIFICATE OF DEATH

Reg. Dist. No.

04186

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ST THOMAS LANE</u>		d. STREET ADDRESS <u>1st THOMAS</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>ALEXANDER</u> Last <u>ALEXANDER</u>		4. DATE OF DEATH <u>4-18-58</u> Month <u>4</u> Day <u>18</u> Year <u>19</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-26-1882</u> 76 yrs.
9. AGE (In years lost birthday) <u>76</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Chemist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>J. S. Young Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>British Subject</u>	
13. FATHER'S NAME <u>William ALEXANDER</u>		14. MOTHER'S MAIDEN NAME <u>TERESA MALLEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Katherine F. Alexander</u> Address <u>OWINGS MILLS</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO <u>arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>15 hrs +</u> <u>3 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 26, 1939</u> to <u>Apr 17, 1958</u> that I last saw the deceased alive on <u>Apr 17, 1958</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Palmer F C Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>Pikeville 8. Md.</u> DATE SIGNED <u>April 18, 58</u>	
PHYSICIAN'S NAME (Type) <u>PALMER F. C. WILLIAMS</u>		<u>Pikeville 8. Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-21-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. THOMAS</u>		22d. LOCATION (City, town, or county) (State) <u>OWINGS MILLS, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 24 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>			

APR 25 1969

RECEIVED

4215

CERTIFICATE OF DEATH

04187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8113 Dalesford Rd.</u>		/d. STREET ADDRESS <u>8113 Dalesford Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>E.</u> Last <u>Allen</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tag Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown Allen</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes W W 1</u>		16. SOCIAL SECURITY NO. <u>578-01-8787</u>	
17. INFORMANT <u>Mrs. Pearl V. Allen</u>		Address <u>8113 Dalesford Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>many years</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8</u> , 19 <u>54</u> , to <u>April 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-1</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5713 Belair Rd Baltimore</u> DATE SIGNED <u>4-10-58</u> ACTUAL SIGNATURE <u>Max R. English</u> M.D. <u>(Dr. John H. Hale)</u> PHYSICIAN'S NAME (Type) <u>Max R. English, M.D.</u> <u>consulted</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 12, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>(Signature)</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
CERTIFICATE OF DEATH

RECEIVED
APR 14 1938
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4216 CERTIFICATE OF DEATH

Reg. Dist. No. 04188

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1½ yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 703 W. Joppa Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LYDIA Middle ANN Last ALLISON		4. DATE OF DEATH Month April Day 23 , Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 30, 1883
9. AGE (In years last birthday) yrs. 74		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Herschel Allison Acklin		14. MOTHER'S MAIDEN NAME Rachel Jane Hackney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO.	
17. INFORMANT Dr. Robert H. Allison		Address 8815 Welverton Rd. Towson Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic & Hypertensive Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 7 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/30/51 , 19 51 , to 4/23 , 19 58 , that I last saw the deceased alive on 12/15 , 19 57 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 14 E. Eager St, Balt & Md DATE SIGNED 4/24/58 ACTUAL SIGNATURE C. Edward Leach M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal/Burial		22b. DATE THEREOF Apl. 24, 1958	
22c. NAME OF CEMETERY OR CREMATORY Redstone Cemetery		22d. LOCATION (City, town, or county) (State) Brownsville, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE APR 28 '58	
24b. REGISTRAR'S SIGNATURE Alfred Smith			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

APR 28 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4217 CERTIFICATE OF DEATH

Reg. Dist. No. 04189

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balti.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 ESSEX</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1804 MYRTH AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>G.</u> Last <u>AMILON</u>		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/14/1898</u> 9. AGE (In years last birthday) <u>60</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>AUGUST KIEFFER</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET HENSHAW</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>NICK SCARANGELLI</u> Address <u>804 MYRTH AVE</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Venous thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>April</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/21/58</u> , 19 <u>58</u> , and that death occurred at <u>5:45</u> AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>815 EASTER IV. BALT. 21</u> DATE SIGNED <u>4/22/58</u>	
ACTUAL SIGNATURE <u>R. J. LYDEN</u> M.D.			
PHYSICIAN'S NAME (Type) <u>R. J. LYDEN, M.D.</u>			

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT CARMEL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blanche F. Hoffman</u> ADDRESS <u>3218 HUDSON ST.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 24 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE	
3. AGE 65		4. DATE OF BIRTH 1885	
5. PLACE OF BIRTH NEW YORK		6. OCCUPATION CLERK	
7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 1910	
9. NAME OF SPOUSE MARY J. BROWN		10. DATE OF DEATH 1950	
11. PLACE OF DEATH HOME		12. CAUSE OF DEATH HEART DISEASE	
13. MEDICAL HISTORY None		14. SIGNATURE OF PHYSICIAN [Signature]	
15. SIGNATURE OF REGISTRAR [Signature]		16. OFFICIAL SEAL [Seal]	

RECEIVED
APR 2 1950
BUREAU V. L.

CERTIFICATE OF DEATH

Reg. Dist. No.

04190

4218

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle May Rose Last Anderson				4. DATE OF DEATH Month April Day 4 Year 19 58			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 9, 1878	
9. AGE (In years last birthday) yrs. 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles W. Rose				14. MOTHER'S MAIDEN NAME Grace Stansbury			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis, severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 6 , 19 58 , to April 4 , 19 58 , that I last saw the deceased alive on April 4 , 19 58 , and that death occurred at 10:40a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-4-58			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/7/58		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell				ADDRESS Chae.		24a. REC'D BY REGISTRAR DATE APR 15 '58	
				24b. REGISTRAR'S SIGNATURE W. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 123

BUREAU V. S.

APR 15 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4219 CERTIFICATE OF DEATH

Reg. Dist. No. 04191

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u> 83X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sheppard Pratt Hosp.</u>		d. STREET ADDRESS <u>1400 Annistead Bridge Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>(NMI)</u> Last <u>Barr</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 21, 1894</u> 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jeweler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Jewelry Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Barr</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Blume</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1st W.A.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocardial degeneration</u> DUE TO (c) <u>+</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>5 yr +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pre-senile dementia</u> <u>15 yr</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 14, 1953</u> to <u>April 3, 1958</u> , that I last saw the deceased alive on <u>April 3, 1958</u> , and that death occurred at <u>5:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. W. Elgin</u>		ADDRESS (Street, city or town, state) <u>Sheppard Pratt Hosp. Towson - 4, Md.</u> DATE SIGNED <u>April 3, 1958</u>	
PHYSICIAN'S NAME (Type) <u>W. W. Elgin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>4-4-58</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Norfolk Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc 2100 Eutaw Place</u>		24a. REC'D BY REGISTRAR <u>APR 7 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. Branch</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1893		BALTIMORE		MD		MD		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		ETHNIC ORIGIN		SPECIAL INSTRUCTIONS	
Carpenter		High School		Married		Catholic		White		White		Caucasian			
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH	
APR 10 1958		10:30 AM		HOME		HEART DISEASE		NATURAL		YES		YES		YES	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	
DATE OF REGISTRATION		TIME OF REGISTRATION		PLACE OF REGISTRATION		CAUSE OF REGISTRATION		MANNER OF REGISTRATION		CERTIFICATE OF REGISTRATION		CERTIFICATE OF REGISTRATION		CERTIFICATE OF REGISTRATION	
APR 11 1958		10:30 AM		HOME		HEART DISEASE		NATURAL		YES		YES		YES	
SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	

BUREAU V. S.

APR 7 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4220 CERTIFICATE OF DEATH

04192

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beekleyville (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beekleyville (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>✓</u>		d. STREET ADDRESS <u>✓</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>G - HOWARD - BAUBLITZ</u>		4. DATE OF DEATH <u>April 12 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13-1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geo W Baublitz</u>		14. MOTHER'S MAIDEN NAME <u>May L Sinclair</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Clarence Baublitz - Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> DUE TO <u>334X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>334X</u> DUE TO (c) <u>334X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1956</u> , to <u>April 12 1958</u> , that I last saw the deceased alive on <u>April 12 1958</u> , and that death occurred at <u>7:53p M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		DATE SIGNED <u>4-14-58</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 15 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salem - Ev. W. B.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Gipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>APR 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>West coach</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

BUREAU V. S.

APR 16 1959

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4221

CERTIFICATE OF DEATH

Reg. Dist. No. 04193

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Likesville</u>				c. LENGTH OF STAY IN 1b <u>Hayes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3307 Smith Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JACOB</u> Middle <u>P.</u> Last <u>BAUMOHL</u>				4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 28, 1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wall Paper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Proprietor</u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Bernard Bauml</u>				14. MOTHER'S MAIDEN NAME <u>Sannie Kessler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-18-9672</u>			
17. INFORMANT <u>Mrs. Lillian Bauml</u> Address <u>Same</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>5 years +</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 minute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May</u> , 19 <u>52</u> to <u>April 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 27</u> , 19 <u>58</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alan Bernstein</u> M.D.				ADDRESS (Street, city or town, state) <u>819 Park Ave Baltimore MD</u>			
PHYSICIAN'S NAME (Type) <u>Alan Bernstein</u>				DATE SIGNED <u>4/9/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Brown</u> ADDRESS <u>1124-26 W. North Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

APR 11 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04194

4222

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9005 Harford Road #14</i>		d. STREET ADDRESS <i>8111 Old Harford Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mr. Charles M. Bealmear</i>		4. DATE OF DEATH <i>April 18 1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 18, 1906</i>
9. AGE (In years last birthday) <i>51</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Loretta M. Bealmear,</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> <i>420.1</i> DUE TO <i>Coronary artery disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerosis premature</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>1 yr</i> <i>?</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>6 Wks ago - Previous Coronary Thrombosis & failure</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <i>9.</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 1</i> , 19 <i>58</i> , to <i>April 18</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>April 18</i> , 19 <i>58</i> , and that death occurred at <i>8:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank T. Kasik, Jr.</i>		ADDRESS (Street, city or town, state) <i>9005 Harford Rd, Balto 14, Md.</i>	
DATE SIGNED <i>4/18/58</i>			
PHYSICIAN'S NAME (Type) <i>FRANK T. KASIK, JR</i>			
22a. BURIAL, CREMATION, REINTERMENT (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/21/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lepnard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>APR 21 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Al. Leason</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04195

4223

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. LENGTH OF STAY IN 1b 61 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 371 TOWNSEND ROAD		d. STREET ADDRESS 371 TOWNSEND ROAD	
3. NAME OF DECEASED (Type or print) FRANK L. BEITZ		4. DATE OF DEATH APRIL 16, 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 5, 1883
9. AGE (In years last birthday) 75 yrs.		10. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR WORKER RETIRED		10b. KIND OF BUSINESS OR INDUSTRY GERMANY	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHRISTIAN BEITZ		14. MOTHER'S MAIDEN NAME AMELIA BOLTZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214 03 0394	
17. INFORMANT MR. FREDERICK BEITZ		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 420.0 DUE TO AURICULAR FIBRILLATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROTIC HEART DISEASE (c) 7YR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT 22, 1951 , to APR. 16, 1958 , that I last saw the deceased alive on APR. 15 , 19 58 , and that death occurred at 12:50 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Miceli M.D.		ADDRESS (Street, city or town, state) 108 S. TAYLOR AVE DATE SIGNED 4/18/58	
PHYSICIAN'S NAME (Type) JOSEPH MICELI M.D.		ESSEX 21 MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/19/58	22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY	22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC BALTIMORE MD.		24a. REC'D BY REGISTRAR APR 21 '58 24b. REGISTRAR'S SIGNATURE Reberich	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

PLACE OF DEATH		DATE OF DEATH	
HOSPITAL		APR 19 1928	
CITY		BALTIMORE	
COUNTY		BALTIMORE	
STATE		MARYLAND	
AGE		28	
SEX		M	
RACE		W	
EDUCATION		HIGH SCHOOL	
OCCUPATION		LABORER	
MARRIAGE		MARRIED	
PREVIOUS ILLNESS		NONE	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. H. WILSON	
SIGNATURE OF REGISTRAR		J. H. WILSON	

DATE OF DEATH		APR 19 1928	
PLACE OF DEATH		HOSPITAL	
CITY		BALTIMORE	
COUNTY		BALTIMORE	
STATE		MARYLAND	
AGE		28	
SEX		M	
RACE		W	
EDUCATION		HIGH SCHOOL	
OCCUPATION		LABORER	
MARRIAGE		MARRIED	
PREVIOUS ILLNESS		NONE	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. H. WILSON	
SIGNATURE OF REGISTRAR		J. H. WILSON	

DATE OF DEATH		APR 19 1928	
PLACE OF DEATH		HOSPITAL	
CITY		BALTIMORE	
COUNTY		BALTIMORE	
STATE		MARYLAND	
AGE		28	
SEX		M	
RACE		W	
EDUCATION		HIGH SCHOOL	
OCCUPATION		LABORER	
MARRIAGE		MARRIED	
PREVIOUS ILLNESS		NONE	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		J. H. WILSON	
SIGNATURE OF REGISTRAR		J. H. WILSON	

RECEIVED

BUREAU OF VITALS

APR 19 1928

APR 12 1928

JOHN WILSON M.D.

100 S. TAYLOR AVE

JOHN WILSON

4224

CERTIFICATE OF DEATH

04196

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PAUL Middle A. Last BENNER				4. DATE OF DEATH Month April Day 4 Year 19 58			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 23, 1895	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Test Baker				10b. KIND OF BUSINESS OR INDUSTRY Mfg. Prepared Mixes			
13. FATHER'S NAME Conrad Henry Benner				14. MOTHER'S MAIDEN NAME Olga Erni			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) No 1 World War				16. SOCIAL SECURITY NO. 220-14-2362		17. INFORMANT Mr. Paul E. Benner - 2617 Larchmont Dr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum with Metastases 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 16 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 22, 1949 , to April 4, 1958 , that I last saw the deceased alive on April 3, 1958 , and that death occurred at 5 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2320 EUTAW PLACE DATE SIGNED ACTUAL SIGNATURE Daniel J. Schwartz M.D. PHYSICIAN'S NAME (Type) DANIEL J. SCHWARTZ							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/58		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickers & Son - Balto 17				24a. REC'D BY REGISTRAR W. Beach		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4225

CERTIFICATE OF DEATH

Reg. Dist. No.

04197

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 209 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 6319 TOONE STREET	
3. NAME OF DECEASED (Type or print) First HARRY Middle E Last BIRCKHEAD		4. DATE OF DEATH Month APRIL Day 20 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 11, 1897
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTROTYPYER		10b. KIND OF BUSINESS OR INDUSTRY ELECTROTYPE COMPANY BALTIMORE, MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM R. BIRCKHEAD		14. MOTHER'S MAIDEN NAME LUCY MAY WHEATLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-1		16. SOCIAL SECURITY NO. 215-01-7522	
17. INFORMANT CLIN REC VET ADM HOSP FORT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR PULMONALE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY EMPHYSEMA DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 4 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 23 19 57 , to April 20 , 19 58 , that I last saw the deceased alive on April 19 19 58 , and that death occurred at 5:50 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4/21/58 ACTUAL SIGNATURE Chien Wei Lan M.D. PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. VAH, FORT HOWARD, MARYLAND			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-23-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc 6009 Harford Rd Balto Md		24a. REC'D BY REGISTRAR DATE APR 22 '58	
24b. REGISTRAR'S SIGNATURE Alfred Smith			

CERTIFICATE OF DEATH

REG. DIST. NO.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE

PLACE

TIME

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

BUREAU W. L.

APR 23 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 04198

1. PLACE OF DEATH a. COUNTY BALTO. CO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE 329 Register b. COUNTY BALTO. CO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROGERS FORGE		c. LENGTH OF STAY IN 1b 12 yr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 322 Register Ave.		e. STREET ADDRESS MARYLAND	
3. NAME OF DECEASED (Type or print) SARAH ELLEN Bollinger		4. DATE OF DEATH Month APRIL Day 11 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-29-78
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) U.S.A. MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Selter		14. MOTHER'S MAIDEN NAME Richardson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT Wilbur Bollinger - son		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ART. SCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20 MIN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-11 8 PM 1958 , to 4-11 4:12 PM 1958 , that I last saw the deceased alive on 4-11 8:10 PM 1958 , and that death occurred at 8:15 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 321 DUNKIRK RD DATE SIGNED 4/12/58	
ACTUAL SIGNATURE C. Victor Richards M.D.		PHYSICIAN'S NAME (Type) C. VICTOR RICHARDS, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-14-58	22c. NAME OF CEMETERY OR CREMATORY Calvary	22d. LOCATION (City, town, or county) (State) Gamber, Carroll, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR APR 15 '58 24b. REGISTRAR'S SIGNATURE Qu. K. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. 2

APR 15 1959

RECEIVED

1-1-59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04199

Items 15&16 G228 5/5/58 GTE

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 29 Portship Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUIS Middle BOLSTAD Last BOLSTAD		4. DATE OF DEATH Month April Day 24 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept, 5, 1888
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel worker-ret.		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jens Bolstad		14. MOTHER'S MAIDEN NAME Helena Lonnie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. Yes		16. SOCIAL SECURITY NO. 213-09-1239	
17. INFORMANT Mrs. Ellen Bolstad		Address 29 Portship Road-22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X CARCINOMA OF Prostate DUE TO C Metastasis to Brain etc. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 1-yr =
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 24, 1958 to April 24, 1958 that I last saw the deceased alive on April 24, 1958 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. B. Davis		DATE SIGNED 7/16/58	
PHYSICIAN'S NAME (Type) M. B. Davis M.D.		ADDRESS (Street, city or town, state) 6800 MORTINGTON ROAD - Dundalk - 22 Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 28, 1958	22c. NAME OF CEMETERY OR CREMATORY Foreland Memorial Park	22d. LOCATION (City, town, or county) (State) Parkville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ulrich Funeral Home		ADDRESS 2112 Dundalk Ave.	
24a. REC'D BY REGISTRAR DATE APR 28 '58		24b. REGISTRAR'S SIGNATURE Alberich	

BUREAU V. 8

APR 29 1958

RECEIVED

04200

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN lb 7 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GARNET FAIRFAX BOWLING		4. DATE OF DEATH Month APRIL Day 18 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH DEC. 22 1900		9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 5 Days 7 Hours 15 Min. 00	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARMACIST		11b. KIND OF BUSINESS OR INDUSTRY RETAIL PHARMACY		11c. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ARTHUR W. BOWLING		14. MOTHER'S MAIDEN NAME NORA W. CLARKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 281-12-9886		17. INFORMANT Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 602X (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① PULMONARY TUBERCULOSIS ② ESOPHAGEAL VARICES & HEMORRHAGE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____		(County) _____		(State) _____	
21. I certify that I attended the deceased from 8/29 , 19 57 , to 4/18 , 19 58 , that I last saw the deceased alive on 4/18 , 19 58 , and that death occurred at 8 A. , M., from the causes and on the date stated above ADDRESS (Street, city or town, state) Mt. Wilson, Maryland		DATE SIGNED _____			
ACTUAL SIGNATURE William Newcomer		M.D. _____			
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent _____			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-22-58		22c. NAME OF CEMETERY OR CREMATORY Buchanan	
22d. LOCATION (City, town, or county) Buchanan, Virginia		(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE Barbara W. Schwab		24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE Al. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

RECEIVED

APR 21 1938

BUREAU V. S.

① Primary Tuberculosis (Examination Index Insurance and ...)

Primary Tuberculosis

No

Primary W. B. ...

W. B. ...

Primary W. B. ...

U.S.A.

DATE X

Dec 22 1930

Garret ...

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4228

04201

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 186 Cherrydell Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>186 Cherrydell Rd.</u>				d. STREET ADDRESS <u>1 Catonsville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>Riston</u> Last <u>Boyer Sr.</u>				4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1898</u>		9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Whls. Liquor</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Boyer</u>				14. MOTHER'S MAIDEN NAME <u>Hannah -----</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.I</u>		17. INFORMANT <u>Edwin Boyer Jr., 52 Dungarrie Rd. 28</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-22-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		22d. LOCATION (City, town, or county) <u>Balto. Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home Catonsville Md.</u>				24a. REC'D BY REGISTRAR <u>APR 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 2 1965

RECEIVED

4229

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Woodlawn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6302 Mt. Alto Rd.</u>		d. STREET ADDRESS <u>6302 Mt. Alto Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>P.</u> Last <u>Brodt</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 5, 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Brodt</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Brodt.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Karl Engelmann</u>		Address <u>-6302 Mt. Alto Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis</u> DUE TO (c) <u>Chronic Arthritic</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>30 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mch. 1956</u> , to <u>April 18, 1958</u> , that I last saw the deceased alive on <u>April 18, 1958</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Coral Gordon</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>3008 North Ave</u> <u>4-21-58</u>	
PHYSICIAN'S NAME (Type) <u>Coral Gordon</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>	
24a. REC'D BY REGISTRAR <u>APR 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938



EDWARD

BUREAU V. 8

APR 23 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4230 CERTIFICATE OF DEATH

Reg. Dist. No. 04204

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALDWIN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.R. #1 CARROLL MANOR RD</u>				d. STREET ADDRESS <u>Carroll Manor Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>PHILLIP</u> Last <u>BUCKINGHAM</u>				4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. STATUS <u>WIDOWED</u>		8. DATE OF BIRTH <u>10/2/1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>23</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARDENTER - RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>EMMORTON, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>WILLIAM BAILEY BUCKINGHAM</u>				14. MOTHER'S MAIDEN NAME <u>MARY ROLLES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-14-5508</u>		17. INFORMANT <u>MR. RICHARD M. BUCKINGHAM</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral sclerosis</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1930</u> to <u>April 24, 1958</u> , that I last saw the deceased alive on <u>April 24, 1958</u> , and that death occurred at <u>10 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Baldwin</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>Halter M. S. Vannett</u>				PHYSICIAN'S NAME (Type) <u>Halter M. S. Vannett</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tichner & Sons - Balto</u>				24a. REC'D BY REGISTRAR DATE <u>APR 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Tichner</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

APR 28 1958

RECEIVED

CERTIFICATE OF DEATH

04205

1. NAME OF DECEASED (Type or Print) **4231 FRANKLIN H. BUPPERT, SR.**

2. DATE OF DEATH **April 8, 1958**

3. PLACE OF DEATH
A. Baltimore City, *Baltimore County*
B. FULL NAME OF (If not in hospital or institution, give street address or location)
3302 Washington Blvd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.**
B. COUNTY **Balto.**
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore
D. STREET ADDRESS (If rural, give location)
3302 Washington Blvd.

5. SEX **male** 6. COLOR OR RACE **white** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **married**

8. DATE OF BIRTH **Apr. 12, 1891** 9. AGE (In years last birthday) **66**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Printer** 10B. KIND OF BUSINESS OR INDUSTRY **Commercial Job Prntg**

11. BIRTHPLACE (State or foreign country) **Pa.** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **George Buppert** 14. MOTHER'S MAIDEN NAME **Mace ?**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **no** (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. **215-01-1058** 17. INFORMANT ADDRESS **Mrs. Stella V. Buppert-3302 Washington Blv**

18. **151X** CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Cancer of Stomach
DUE TO
(A) **Cancer of Stomach**
(B) **8 mos.?**
(C) **INTERVAL BETWEEN ONSET AND DEATH**

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) **DUE TO**
(C) **DUE TO**

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY? YES ☐ NO ☒

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from **August 26, 1957** to **April 8, 1958**, that (I) (the) last saw the deceased alive on **April 8, 1958**, and that death occurred at **6:30 P. m.**, from the causes and on the date stated above.

23A. SIGNATURE **P. Ritten Rosenberg M.D.** 23B. ADDRESS **1436 Washington Blvd. 30** 23C. DATE SIGNED **4/9/58**

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **4/12/58** 24C. NAME OF CEMETERY OR CREMATORY **Loudon Park Cem.** 24D. LOCATION (City, town, or county) (State) **Balto., Md.**

DATE RECEIVED BY LOCAL REGISTRAR **APR 9 - 1958** 25. FUNERAL DIRECTOR **Wm. S. Tucker & Sons** ADDRESS **1436 Washington Blvd. 30**

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

1

After death.

After this

of this

RECEIVED
JAN 17 1960
BUREAU V. S.

105 41 656

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04206**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b 2 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Randallstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3704 Courtleigh Dr.			d. STREET ADDRESS 3704 Courtleigh Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Kathleen Middle A. Last Burrier			4. DATE OF DEATH Month Apr. Day 4 Year 191958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1953		9. AGE (In years last birthday) 4 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Calvin Burrier			14. MOTHER'S MAIDEN NAME Dorothy Buczkowski		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Calvin Burrier, 3704 Courtleigh Dr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Vomitus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Concussion DUE TO (c) Fall in bath tub					INTERVAL BETWEEN ONSET AND DEATH 10 hrs. 10 hrs. 14 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased fell in bath tub about 5PM, Apr. 3, 1958			
20c. TIME OF INJURY Month, Day, Year 5 3:30 4-3-58 19 Hour 3:30 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) Randallstown, Balto., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE D. D. Caples			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) D. D. Caples, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 7, 1958	22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	22d. LOCATION (City, town, or county) (State) BALTO, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir., 4101 Edmondson Ave.			24a. REC'D BY REGISTRAR APR 9 '58	24b. REGISTRAR'S SIGNATURE Witzke	

BUREAU V. S.

APR 9 1958

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04207**

1. PLACE OF DEATH a. COUNTY Baltimore Catonsville MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12 Jones Row.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Elizabeth Middle Burton		4. DATE OF DEATH Month April Day 3 Year 1958	
5. SEX Fem	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 6. 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Howard Co. Md		12. CITIZEN OF WHAT COUNTRY? usa	
13. FATHER'S NAME Henry Bruce		14. MOTHER'S MAIDEN NAME Mary Hammond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 210 2	
17. INFORMANT Sam Stoll		Address Gross Mtn Ln	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo. S. M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/1958	
22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate R. Williams		ADDRESS 322 N. Schroeder St.	
24a. REC'D BY REGISTRAR APR 9 '58		24b. REGISTRAR'S SIGNATURE W. J. Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4234 CERTIFICATE OF DEATH

Reg. Dist. No. 04209

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 88 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle L Last CARMAN		4. DATE OF DEATH Month APRIL Day 6 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 28 1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10b. KIND OF BUSINESS OR INDUSTRY APARTMENT HOUSE	
11. BIRTHPLACE (State or foreign country) CAMDEN, NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY E CARMAN		14. MOTHER'S MAIDEN NAME MOLLIE OSBOURN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 219-03-5510	
17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FIBROSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PORTAL CIRRHOSIS			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY 8 , 19 58 , to APRIL 6 , 19 58 , and that death occurred at 11:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald D Mark		ADDRESS (Street, city or town, state) VAH Fort Howard Maryland DATE SIGNED 4-6-58	
PHYSICIAN'S NAME (Type) DONALD D MARK		M.D. M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-10-58	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WM. COOK-BLIGHT INC 6009 HARFORD ROAD BALTO MD		24a. REC'D BY REGISTRAR DATE APR 10 '58	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Yearly

1934-1935

BUREAU V. S.

APR 11 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4235

CERTIFICATE OF DEATH

Reg. Dist. No.

04210

1. PLACE OF DEATH a. COUNTY <i>Balto Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson 4</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Towson Convalescent Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>HARRIET</i> First <i>A</i> Middle <i>Childs</i> Last		4. DATE OF DEATH Month <i>Apr</i> Day <i>10</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 31-1873</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>William P. Dadd</i>		14. MOTHER'S MAIDEN NAME <i>Henrietta Hayman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Elinore Bunt</i>		Address <i>706 Plymouth Rd. Pikesville Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Bladder</i> <i>181.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Secondary Anemia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-24</i> 19 <i>58</i> , to <i>April 10</i> 19 <i>58</i> , that I last saw the deceased alive on <i>April 10</i> 19 <i>58</i> , and that death occurred at <i>10:15 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Laurence C. Post</i> M.D.		ADDRESS (Street, city or town, state) <i>6805 York Rd. Baltimore 12 Md.</i>	
PHYSICIAN'S NAME (Type) <i>LAURENCE C. Post</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-13-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Annus</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. RECORD BY REGISTRAR <i>APR 14 1958</i>	24b. REGISTRAR'S SIGNATURE <i>W. J. Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 14 1958

RECEIVED

4236 CERTIFICATE OF DEATH

Reg. Dist. No. 04211

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, rural</u>				c. LENGTH OF STAY IN lb <u>(27)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3204 Hilltop Avenue</u>				d. STREET ADDRESS <u>3204 Hilltop Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Charles A. Christner</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 5, 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Christner</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Sally V. Christner</u>				Address <u>3204 Hilltop Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, diffuse</u> DUE TO (c) <u>6 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 27, 1958</u> , to <u>April 6, 1958</u> , that I last saw the deceased alive on <u>Feb. 29, 1958</u> , and that death occurred at <u>3:20 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Arthur Rossberg</u>				ADDRESS (Street, city or town, state) <u>2436 Washington Bld</u>			
PHYSICIAN'S NAME (Type) <u>C. ARTHUR ROSSBERG</u>				DATE SIGNED <u>4/7/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 9, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Miller Inc.</u>				ADDRESS <u>2431-35 E. Ohio St.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 11 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained in hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1938 CERTIFICATE OF DEATH

PLACE IN BOXES		MARRIAGE		PLACE IN BOXES	
1. DATE OF DEATH		2. COUNTY OF DEATH		3. PLACE OF DEATH	
4. SEX		5. AGE		6. OCCUPATION	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BURIAL	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERGYMAN		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF SHERIFF		17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF COUNTY CLERK		21. SIGNATURE OF TOWNSHIP CLERK	
22. SIGNATURE OF VOTING CLERK		23. SIGNATURE OF POLLING CLERK		24. SIGNATURE OF BALLOT CLERK	
25. SIGNATURE OF BALLOT BOX CLERK		26. SIGNATURE OF BALLOT BOX CLERK		27. SIGNATURE OF BALLOT BOX CLERK	
28. SIGNATURE OF BALLOT BOX CLERK		29. SIGNATURE OF BALLOT BOX CLERK		30. SIGNATURE OF BALLOT BOX CLERK	
31. SIGNATURE OF BALLOT BOX CLERK		32. SIGNATURE OF BALLOT BOX CLERK		33. SIGNATURE OF BALLOT BOX CLERK	
34. SIGNATURE OF BALLOT BOX CLERK		35. SIGNATURE OF BALLOT BOX CLERK		36. SIGNATURE OF BALLOT BOX CLERK	
37. SIGNATURE OF BALLOT BOX CLERK		38. SIGNATURE OF BALLOT BOX CLERK		39. SIGNATURE OF BALLOT BOX CLERK	
40. SIGNATURE OF BALLOT BOX CLERK		41. SIGNATURE OF BALLOT BOX CLERK		42. SIGNATURE OF BALLOT BOX CLERK	
43. SIGNATURE OF BALLOT BOX CLERK		44. SIGNATURE OF BALLOT BOX CLERK		45. SIGNATURE OF BALLOT BOX CLERK	
46. SIGNATURE OF BALLOT BOX CLERK		47. SIGNATURE OF BALLOT BOX CLERK		48. SIGNATURE OF BALLOT BOX CLERK	
49. SIGNATURE OF BALLOT BOX CLERK		50. SIGNATURE OF BALLOT BOX CLERK		51. SIGNATURE OF BALLOT BOX CLERK	
52. SIGNATURE OF BALLOT BOX CLERK		53. SIGNATURE OF BALLOT BOX CLERK		54. SIGNATURE OF BALLOT BOX CLERK	
55. SIGNATURE OF BALLOT BOX CLERK		56. SIGNATURE OF BALLOT BOX CLERK		57. SIGNATURE OF BALLOT BOX CLERK	
58. SIGNATURE OF BALLOT BOX CLERK		59. SIGNATURE OF BALLOT BOX CLERK		60. SIGNATURE OF BALLOT BOX CLERK	
61. SIGNATURE OF BALLOT BOX CLERK		62. SIGNATURE OF BALLOT BOX CLERK		63. SIGNATURE OF BALLOT BOX CLERK	
64. SIGNATURE OF BALLOT BOX CLERK		65. SIGNATURE OF BALLOT BOX CLERK		66. SIGNATURE OF BALLOT BOX CLERK	
67. SIGNATURE OF BALLOT BOX CLERK		68. SIGNATURE OF BALLOT BOX CLERK		69. SIGNATURE OF BALLOT BOX CLERK	
70. SIGNATURE OF BALLOT BOX CLERK		71. SIGNATURE OF BALLOT BOX CLERK		72. SIGNATURE OF BALLOT BOX CLERK	
73. SIGNATURE OF BALLOT BOX CLERK		74. SIGNATURE OF BALLOT BOX CLERK		75. SIGNATURE OF BALLOT BOX CLERK	
76. SIGNATURE OF BALLOT BOX CLERK		77. SIGNATURE OF BALLOT BOX CLERK		78. SIGNATURE OF BALLOT BOX CLERK	
79. SIGNATURE OF BALLOT BOX CLERK		80. SIGNATURE OF BALLOT BOX CLERK		81. SIGNATURE OF BALLOT BOX CLERK	
82. SIGNATURE OF BALLOT BOX CLERK		83. SIGNATURE OF BALLOT BOX CLERK		84. SIGNATURE OF BALLOT BOX CLERK	
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88. SIGNATURE OF BALLOT BOX CLERK		89. SIGNATURE OF BALLOT BOX CLERK		90. SIGNATURE OF BALLOT BOX CLERK	
91. SIGNATURE OF BALLOT BOX CLERK		92. SIGNATURE OF BALLOT BOX CLERK		93. SIGNATURE OF BALLOT BOX CLERK	
94. SIGNATURE OF BALLOT BOX CLERK		95. SIGNATURE OF BALLOT BOX CLERK		96. SIGNATURE OF BALLOT BOX CLERK	
97. SIGNATURE OF BALLOT BOX CLERK		98. SIGNATURE OF BALLOT BOX CLERK		99. SIGNATURE OF BALLOT BOX CLERK	
100. SIGNATURE OF BALLOT BOX CLERK		101. SIGNATURE OF BALLOT BOX CLERK		102. SIGNATURE OF BALLOT BOX CLERK	

RECEIVED
APR 11 1938
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4237

CERTIFICATE OF DEATH

Reg. Dist. No.

04212

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3yr3mth15dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Smith Last Chute				4. DATE OF DEATH Month April Day 11 Year 19 58			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 14, 1877	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Thomas Smith				14. MOTHER'S MAIDEN NAME Edith Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records; SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from April 7, 1958 , to April 11, 1958 , that I last saw the deceased alive on April 11, 1958 , and that death occurred at 4:00p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Bruno Radauskas				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-11-58			
PHYSICIAN'S NAME (Type) Bruno Radauskas, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Apr. 14, 1958		22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.				ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR APR 15 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Smith			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE ONE IN

RECEIVED
APR 15 1939
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04213

4238 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 33 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 1732 NORTH CAREY STREET	
3. NAME OF DECEASED (Type or print) First JOHN Middle W Last CLARK		4. DATE OF DEATH Month APRIL Day 6 Year 19 58	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 12, 1892
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY PRIVATE FAMILY	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES CLARK		14. MOTHER'S MAIDEN NAME MARY SNOWDEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 220-18-5641	
17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PORTAL CIRRHOSIS 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) COLECTOMY FOR ADENOCARCINOMA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from MARCH 4, 19 58 to APRIL 6, 19 58 and that death occurred at 6:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Donald D Mark</i>		ADDRESS (Street, city or town, state) DATE SIGNED 4-6-58	
PHYSICIAN'S NAME (Type) DONALD D MARK		M.D. VAH Fort Howard Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-9-58	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS CHARLES R LAW MORTUARY 802 MADISON AVE BLATO MD		24a. REC'D BY REGISTRAR DATE APR 8 '58	
		24b. REGISTRAR'S SIGNATURE <i>Albert Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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APR 8 1938

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may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4239 CERTIFICATE OF DEATH

04214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kingsville</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kingsville</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Belair Rd.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Marie E. Cloman</i>			4. DATE OF DEATH <i>April 29 1958</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 20, 1898</i>		9. AGE (In years last birthday) <i>59</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Co., Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>Frank Hartkopf</i>		
14. MOTHER'S MAIDEN NAME <i>Mary A. Sittig</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>No</i> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <i>None</i>			17. INFORMANT <i>Mr. John F. Cloman</i> Address <i>Hydes, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>416X Congestive Heart Failure</i> DUE TO <i>Rheumatic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>260X</i> (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <i>3 days 50 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus - 10 yrs.</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>— 19</i>			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Aug. 22, 1934</i> , to <i>Apr. 29, 1958</i> , that I last saw the deceased alive on <i>Apr. 29, 1958</i> , and that death occurred at <i>8:45 P.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Clifford F. Hudson</i> M.D.			DATE SIGNED <i>FORK, MD.</i>		
PHYSICIAN'S NAME (Type) <i>CLIFFORD F. HUDSON</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 3, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Michael's Lutheran</i>	
22d. LOCATION (City, town, or county) <i>Perry Hall</i>		(State) <i>Balto. Co., Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sasahn Funeral Home</i> ADDRESS <i>7401 Belair Rd.</i>			24a. REC'D BY REGISTRAR <i>DATE APR 30 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Search</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04215

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore 4240 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks c. LENGTH OF STAY IN lb ---- d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harrisburg Expressway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkton d. STREET ADDRESS Mt. Carmel Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard Monroe Cole First Middle Last 4. DATE OF DEATH 4-20-58 Month Day Year		5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 3-5-1901 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Engineer		10b. KIND OF BUSINESS OR INDUSTRY Metr. Dist. Balto. 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James M. Cole		14. MOTHER'S MAIDEN NAME Rebecca Vance	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-07-9596 17. INFORMANT Elsie P. Cole, Parkton, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing Injury to Skull 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased Auto Struck by Another Auto	
20c. TIME OF INJURY Month, Day, Year 7 April 1958 Hour a. m. 7 p. m. 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) Parkton (County) Baltimore (State) MD	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/21/58	
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) Parkton, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR APR 22 '58 24b. REGISTRAR'S SIGNATURE W. J. Couch	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

1



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
1938

NAME: James P. Cole
AGE: 35
SEX: Male
RACE: White
DATE OF BIRTH: 7-2-1901
PLACE OF BIRTH: St. Louis, Mo.
RESIDENCE: Baltimore, Md.
OCCUPATION: Expressman
CAUSE OF DEATH: Heart Disease
MANNER OF DEATH: Natural
DATE OF DEATH: April 28, 1938
PLACE OF DEATH: Home
SIGNATURE OF EXAMINER: James P. Cole
DATE: April 28, 1938

BUREAU Y. 8

APR 28 1938

RECEIVED

APR 28 1938
NEW YORK
NEW YORK

4241 CERTIFICATE OF DEATH

Reg. Dist. No. 04216

1. PLACE OF DEATH o. COUNTY <i>Baltimore 19</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Pa</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparks Pt.</i>	c. LENGTH OF STAY IN 1b <i>19 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X M</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7337 Waldman Ave</i>		d. STREET ADDRESS <i>#1</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>EMMA ELIZA BETH CONNELL</i>		4. DATE OF DEATH Month Day Year <i>APRIL 28 1958</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 28. 1910</i>
9. AGE (In years last birthday) yrs. <i>47</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore. md</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>George Fisher</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Eder.</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>	
16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT Address <i>Joseph Connell - (Husband)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardio Vascular disease 6 yrs</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>8/2</i> , 19 <i>57</i> , to <i>April 28</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>April 28</i> , 19 <i>58</i> , and that death occurred at <i>1 P.</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Louis N. Hallen</i>		ADDRESS (Street, city or town, state) <i>6408 N. 9th Rd. Baltimore 19 - md</i>	
FUNDING NAME (Type) <i>LOUIS N. TOWLIN</i>		DATE SIGNED <i>4/28/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>MAY 1, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>OAK LAWN CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>BALTIMORE Co., MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Brooks Bradley</i>		ADDRESS <i>DUNDALK, MD.</i>	24a. REC'D BY REGISTRAR <i>DATE APR 30 '58</i>
		24b. REGISTRAR'S SIGNATURE <i>W. Lewis</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 1

1. NAME OF DECEASED <i>FRANK WHITE</i>		2. SEX <i>M</i>		3. AGE <i>47</i>		4. DATE OF BIRTH <i>APRIL 28 1878</i>	
5. PLACE OF BIRTH <i>NEW YORK</i>		6. OCCUPATION <i>SALES</i>		7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>	
9. PLACE OF DEATH <i>NEW YORK</i>		10. DATE OF DEATH <i>APRIL 28 1958</i>		11. TIME OF DEATH <i>11:00 PM</i>		12. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
13. SIGNATURE OF REGISTRAR <i>[Signature]</i>		14. SIGNATURE OF WITNESS <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>		16. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>	

BUREAU V. 1

APR 30 1958

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4242

CERTIFICATE OF DEATH

Reg. Dist. No.

04217
32

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>				c. LENGTH OF STAY IN 1b <u>49 1/2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Mt. Wilson State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM M</u> First <u>Buchanan</u> Middle <u>XXXXXXXXXXXX</u> Last <u>COSGRAVE</u>				4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-10-14</u>	
9. AGE (In years last birthday) yrs. <u>43</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>9</u> Hours <u>19</u> Min. <u>58</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>HARRY G. COSGRAVE</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE DIXON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-16-1212</u>		17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS</u> <u>002x</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-28, 1956</u> , to <u>4-9, 1958</u> , that I last saw the deceased alive on <u>4-8, 1958</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mt. Wilson, Maryland</u> DATE SIGNED <u>4-9-58</u> ACTUAL SIGNATURE <u>William Newcomer</u> M.D. SUPERINTENDENT PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>MR. C. H. ...</u> ADDRESS <u>... Frederick Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933



RECEIVED

BUREAU V. 3

APR 10 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4243

CERTIFICATE OF DEATH

Reg. Dist. No.

04218

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>200 W. Pennsylvania Ave.</u>				d. STREET ADDRESS <u>407 Ivy Church Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>FRANCIS</u> Last <u>CROOK, SR.</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>19 58</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u>	8. DATE OF BIRTH <u>June 17, 1901</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Francis Marion Crook</u>				14. MOTHER'S MAIDEN NAME <u>Bianca Mahler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-10-2443</u>		17. INFORMANT <u>Mr. Richard F. Crook, Jr.-3518 Wilc Cherry Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Posterior Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Apr. 19, 1958</u> , to <u>Apr. 19, 1958</u> , that I last saw the deceased alive on <u>Apr. 19, 1958</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Tos. A. Sedlack</u>				ADDRESS (Street, city or town, state) <u>200 W. Pennsylvania Ave. Towson 4, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Tos. A. Sedlack</u>				DATE SIGNED <u>4/21/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickner & Sons - Balto 17</u>				24a. REC'D BY REGISTRAR DATE <u>APR 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Pickner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1958

RECEIVED

RECEIVED

CERTIFICATE OF DEATH

STATE OF MARYLAND - BUREAU OF HEALTH - BALTIMORE 12

FILE NO. 100

DATE OF BIRTH		PLACE OF BIRTH	
DATE OF DEATH		PLACE OF DEATH	
SEX		RACE	
EDUCATION		OCCUPATION	
MARRIAGE		RELIGION	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	

RECEIVED
BUREAU V. S.
 APR 17 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4204

CERTIFICATE OF DEATH

Reg. Dist. No.

04221

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN 1b 53 Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 219 Oaklee Village				d. STREET ADDRESS 876 Mildred Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First GRACE Middle T. Last DAVIS				4. DATE OF DEATH Month April Day 3 Year 19 58			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 27, 1892	
9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (rtd)				10b. KIND OF BUSINESS OR INDUSTRY insurance -- Unknown			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? Maryland			
13. FATHER'S NAME John Davis				14. MOTHER'S MAIDEN NAME Hannah Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-07-0568			
17. INFORMANT Mrs. Nellie Bromwell - 876 Mildred Ave.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3-31-58 19 to 4-3-58 19, that I last saw the deceased alive on 3-31-58 19, and that death occurred at 1:00 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE James R. Grabill M.D.							
PHYSICIAN'S NAME (Type) James R. Grabill M.D.				1945 W. Balto. St. Balto. 23, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 7, 1958		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons - Balt.				24a. REC'D BY REGISTRAR DATE APR 7 '58		24b. REGISTRAR'S SIGNATURE Alfred	

RECEIVED

4246 CERTIFICATE OF DEATH

04222

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4,				c. LENGTH OF STAY IN 1b 2 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 Alabama Ct.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Paul Middle Frisby Last Davis, Sr.				4. DATE OF DEATH Month 4 Day 2 Year 58			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-28-06	
9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR Months 52 Days 52 Hours 52 Min. 52		IF UNDER 24 HRS. Months 52 Days 52 Hours 52 Min. 52			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vic. President				10b. KIND OF BUSINESS OR INDUSTRY construction Co		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Mark N. Davis				14. MOTHER'S MAIDEN NAME Mary Comfort			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 203-03-7994		17. INFORMANT Jennie Lee Davis		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY THROMBOSIS DUE TO (c) CORONARY HEART DISEASE							INTERVAL BETWEEN ONSET AND DEATH ONE MINUTE ONE MINUTE 18 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Towson 4, Md.				20g. (County) Towson 4, Md.		20h. (State) Towson 4, Md.	
21. I certify that I attended the deceased from 2/24 , 19 53 , to 4/2 , 19 58 , that I last saw the deceased alive on 4/1 , 19 58 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald L. Someville				ADDRESS (Street, city or town, state) 25 W. Pa. Ave.		DATE SIGNED 4/5/58	
PHYSICIAN'S NAME (Type) Donald L. Someville, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-5-58		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill		22d. LOCATION (City, town, or county) (State) Towson 4, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks				ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR APR 7 '58	
				24b. REGISTRAR'S SIGNATURE Alfred Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

APR 7 1938

RECEIVED

4247

CERTIFICATE OF DEATH

Reg. Dist. No.

04223

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Freeland</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Freeland</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Freeland Rd</i>				d. STREET ADDRESS <i>Freeland Rd</i>			
3. NAME OF DECEASED (Type or print) First <i>Ernest</i> Middle <i>R.</i> Last <i>Day</i>				4. DATE OF DEATH Month <i>April</i> Day <i>3</i> Year <i>1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 6, 1879</i>	9. AGE (In years last birthday) <i>79</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Stewartstown, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Eugene Martin Day</i>				14. MOTHER'S MAIDEN NAME <i>Emma Duff</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-14-7750</i>		17. INFORMANT Address <i>Mrs. Elizabeth Day, Freeland Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO (c) <i>Arterio-sclerosis</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <i>1957</i> , to <i>Apr. 3, 1958</i> , that I last saw the deceased alive on <i>Apr. 2, 1958</i> , and that death occurred at <i>3:50 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R.M. France</i> M.D.				ADDRESS (Street, city or town, state) <i>Parkton, Md.</i>		DATE SIGNED <i>4/4/58</i>	
PHYSICIAN'S NAME (Type) <i>R.M. FRANCE</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/5/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>West Liberty Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>White Hall Md.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jacob Kautenstern</i> ADDRESS <i>New Freedom, Pa.</i>			24a. REC'D BY REGISTRAR <i>APR 8 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU 45

APR 8 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04224

4248

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home 329 Harlem Lane		d. STREET ADDRESS 1739 N. Charles St	
3. NAME OF DECEASED (Type or print) First Charles Middle Deck Last Deck		4. DATE OF DEATH Month April Day 5 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-28-1886
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Deck		14. MOTHER'S MAIDEN NAME Agusta Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Anna Seybold		Address 5230 Linden Hts Ave-15	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 36 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. 51 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 17 , 19 58 , to April 5 , 19 58 , that I last saw the deceased alive on April 5 , 19 58 , and that death occurred at 10:45 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4605 Edmondson ave DATE SIGNED ACTUAL SIGNATURE Cliff Ratcliff Jr M.D. PHYSICIAN'S NAME (Type) CLIFF RATCLIFF, JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-8-58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE David R. Martin David R. Martin, 1902 Rutaw Place		24a. REC'D BY REGISTRAR DATE APR 11 '58	
24b. REGISTRAR'S SIGNATURE W. H. Leach			

194

BUREAU V. S.

APR 11 1958

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

04225

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Balto</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>HYDE, MD.</u>		LENGTH OF STAY (in this place) <u>33 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HYDE, MD.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GLEN ARM RD.</u>				STREET ADDRESS (If rural give location) <u>GLEN ARM RD.</u>			
3. NAME OF DECEASED (Type or Print) <u>Ceciliz</u> (First) <u>DeFields</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>April 4 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Aug. 13, 1892</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BUFFALO - N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ADOLPH EDELMANN</u>				14. MOTHER'S MAIDEN NAME <u>DOROTHY SCHMALTZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-20-7977</u>		17. INFORMANT & ADDRESS <u>MR. JAY DE FIELDS GLEN ARM RD.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
175.0 IMMEDIATE CAUSE (A) <u>Malignant Ovarian Cystadenoma</u>						<u>2 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>July 29, 1957</u>		19b. MAJOR FINDINGS OF OPERATION <u>Large Ovarian tumor - malignant</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 17, 1957</u> , to <u>April 1, 1958</u> , that I last saw the deceased alive on <u>April 1, 1958</u> , and that death occurred at <u>9:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William A. Tyson</u> M.D.				ADDRESS (Street, city, town, state) <u>Kingville Md.</u>		DATE SIGNED <u>4-4-58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4-7-1958</u>		NAME OF CEMETERY OR CREMATORY <u>FORK METHODIST CEM</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE CO. MD.</u>	
24. REC'D BY REGISTRAR <u>APR 8 '58</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>7401 Belair Rd.</u>	

CERTIFICATE OF DEATH

MARYLAND
HYDE, M.D.
Glen Farm Rd.

BALTIMORE
HYDE, M.D.
Glen Farm Rd.
33 yrs.

NO
550-50-7777 MR 741 DE FIELDS GLEN FARM RD
ADOLPH EDELMAN
HOUSEWIFE AT HOME BALTIMORE - N.Y. N-2-A
F W MARRIED
DOROTHY SCHWAB

BUREAU V. 1

APR 8 1958

RECEIVED

4-1-1958 FORK MEDICIST CEN BALTIMORE CO. MD.

For the purpose of the report...

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04226

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> 4250 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3 Raynor Ave</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Balto.</u> Md b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> 52 d. STREET ADDRESS <u>3 Raynor Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marcella De Persio</u>				4. DATE OF DEATH Month Day Year <u>April 15 1958</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 11, 1892</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				11. BIRTHPLACE (State or foreign country) <u>Italy</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Ludwig De Angelis</u>						14. MOTHER'S MAIDEN NAME <u>unknown</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>Jo Annie Swinn</u> <u>221 Rose St, Balto.</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Coronary Thrombosis</u> (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.															
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>April 15, 1958</u>			
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M. D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Apr 18, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>				22d. LOCATION (City, town, or county) (State) <u>Belair Rd. Maryland.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Schimunek Funeral Home Inc.</u> <u>3331 Brehms Lane.</u> <u>Charles C. Schimunek</u>						24a. REC'D BY REGISTRAR <u>APR 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, certifying the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

APR 21 1958

RECEIVED
APR 31 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4251 CERTIFICATE OF DEATH

Reg. Dist. No.

04227

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balt.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Overlea			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 22 Elmont Ave.				d. STREET ADDRESS 22 Elmont Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Anthony Middle C. Last Dobrowolski				4. DATE OF DEATH Month 4 Day 12 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 12, 1886		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foundry Worker		10b. KIND OF BUSINESS OR INDUSTRY Bartlett-Hayward Co.		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Dobrowolski				14. MOTHER'S MAIDEN NAME Katarzyna Kuczarski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give year or dates of service) None		16. SOCIAL SECURITY NO. 212-07-9530		17. INFORMANT Address Mrs. Stella Dobrowolski 22 Elmont Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lungs 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-3- , 19 57 , to 4-11 , 19 58 , that I last saw the deceased alive on 4-11-58 , 19 58 , and that death occurred at 5:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Richard R. Rigler				ADDRESS (Street, city or town, state) DATE SIGNED 1 W. Overlea Ave. Balto. 6, Md. 4-14-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-16-1958		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, town, or county) (State) Dundalk Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda				ADDRESS 2829 Hudson St. 24, Md.		24a. REC'D BY REGISTRAR DATE APR 16 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
 1938
 CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		AGE [Illegible]		SEX [Illegible]		RACE [Illegible]		DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		CITY OF BIRTH [Illegible]		STATE OF BIRTH [Illegible]		COUNTRY OF BIRTH [Illegible]	
RESIDENCE [Illegible]		OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CITY OF DEATH [Illegible]		STATE OF DEATH [Illegible]		COUNTRY OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]		SIGNATURE OF DEATH REGISTRAR [Illegible]		SIGNATURE OF CLERK [Illegible]		SIGNATURE OF [Illegible]		SIGNATURE OF [Illegible]		SIGNATURE OF [Illegible]		SIGNATURE OF [Illegible]		SIGNATURE OF [Illegible]	

RECEIVED
 APR 16 1938
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04228

4252 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>55</u> <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8706 Raven Drive</u>		d. STREET ADDRESS <u>1 8706 Raven Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. William M. Downey, Sr.</u>		4. DATE OF DEATH Month Day Year <u>April 15, 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Downey</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Houck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. William M. Downey, Jr.</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Associated Cirrhosis of Liver</u> (c) <u>Myocarditis GRADE III</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Anasarca</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 8, 1954</u> to <u>April 15, 1958</u> , that I last saw the deceased alive on <u>April 14, 1958</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. V. Harbold</u> M.D.		ADDRESS (Street, city or town, state) <u>4706 Harford Road #14</u> DATE SIGNED <u>4/16/58</u>	
PHYSICIAN'S NAME (Type) <u>Harold V. Harbold</u>		<u>Baltimore, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>APR 21 1958</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Ruck</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

BUREAU V. S.

APR 21 1938

RECEIVED

4253

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MD. b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GWING'S MILLS				c. LENGTH OF STAY IN 1b 2 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11419 REISTERSTOWN RD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE First FRANCIS Middle ECKENRODE Last				4. DATE OF DEATH APRIL 15 Month 15 Day 1958 Year			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-1874	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UPHOLSTERER				10b. KIND OF BUSINESS OR INDUSTRY MD.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME JOHN E. ECKENRODE				14. MOTHER'S MAIDEN NAME ANNIE E. STONER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 216-22-7805A		17. INFORMANT MRS. MILDRED DE VESE Address 4419 GWINNS MILLS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - generalized DUE TO (c) Years							INTERVAL BETWEEN ONSET AND DEATH MD 36 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July , 19 56 , to April 15 , 19 58 , that I last saw the deceased alive on April 13 , 19 58 , and that death occurred at 4:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles E. Williams M.D.				ADDRESS (Street, city or town, state) Reisterstown, Maryland			
DATE SIGNED April 16, 1958							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-18-58		22c. NAME OF CEMETERY OR CREMATORY ST. JOHNS CEM.		22d. LOCATION (City, town, or county) (State) WESTMINSTER, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE David G. Barckard				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR W. Search	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

For Use by

BUREAU V. 21

PR 17 1938

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>713 Charring Cross</u>		/d. STREET ADDRESS <u>713 Charring Cross</u>	
3. NAME OF DECEASED (Type or print) First <u>EUGENE</u> Middle <u>F.</u> Last <u>BISSELE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker Amrhein Bros</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baker</u>	9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>William Eissele</u>		14. MOTHER'S MAIDEN NAME <u>Dont. Know</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>212-07-9334</u>	
17. INFORMANT <u>Mrs. Anna Bissele</u>		Address <u>713 Charring Cross</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending</u> DUE TO <u>181.0</u> Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of bladder (urinary) inoperable</u> (c) <u> </u> DUE TO <u> </u> cause lost. <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		DATE SIGNED <u>April 11, 1958</u>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine PK.</u>	22d. LOCATION (City, town, or county) <u>Baltimore 7, Md.</u> (State) <u> </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILFRED FUNERAL DIRECTORS, 4101 Edmondson Ave</u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u> </u>
DATE <u>APR 15 '58</u>		DATE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to a burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BACHTHOFF 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PRESENT ILLNESS		14. TREATMENT		15. POST-MORTEM EXAMINATION		16. SIGNATURE OF EXAMINER	
17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF WITNESS		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF JURY		21. SIGNATURE OF CORONER		22. SIGNATURE OF DEPUTY CORONER		23. SIGNATURE OF CLERK		24. SIGNATURE OF REGISTRAR	

BUREAU V. S.

APR 16 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4255

CERTIFICATE OF DEATH

04231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5111 "Q" Street - S. E. - Wash., D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 5111 "Q" Street - S. E.	
3. NAME OF DECEASED (Type or print) First Arthur Middle Vernon Last English		4. DATE OF DEATH Month April Day 28 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1903 July 6, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mathematician		10b. KIND OF BUSINESS OR INDUSTRY Engineering	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert English Benjamin English		14. MOTHER'S MAIDEN NAME Amanda English Rudder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Parkinson's Disease 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition secondary to Parkinson's Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 24, 1958 , to April 28, 1958 , that I last saw the deceased alive on April 28, 1958 , and that death occurred at 6:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4/28/58			
ACTUAL SIGNATURE C. Eugene Watermann		PHYSICIAN'S NAME (Type) C. Eugene Watermann Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/1/58	
22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or county) (State) Forestville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Justice Bros. - 2741 N. Marlboro, Md.		24a. REC'D BY REGISTRAR DATE MAY 6 '58	
24b. REGISTRAR'S SIGNATURE W. H. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician	
11. Signature of Registrar		12. Date of Registration		13. Place of Registration		14. Signature of Coroner		15. Date of Coroner's Report	
16. Signature of Medical Examiner		17. Date of Medical Examination		18. Place of Medical Examination		19. Signature of Burial Officer		20. Date of Burial	
21. Signature of Undertaker		22. Date of Undertaking		23. Place of Undertaking		24. Signature of Cemetery Officer		25. Date of Cemetery Report	
26. Signature of Health Officer		27. Date of Health Officer's Report		28. Place of Health Officer's Report		29. Signature of Burial Officer		30. Date of Burial	
31. Signature of Registrar		32. Date of Registration		33. Place of Registration		34. Signature of Coroner		35. Date of Coroner's Report	
36. Signature of Medical Examiner		37. Date of Medical Examination		38. Place of Medical Examination		39. Signature of Burial Officer		40. Date of Burial	
41. Signature of Undertaker		42. Date of Undertaking		43. Place of Undertaking		44. Signature of Cemetery Officer		45. Date of Cemetery Report	
46. Signature of Health Officer		47. Date of Health Officer's Report		48. Place of Health Officer's Report		49. Signature of Burial Officer		50. Date of Burial	
51. Signature of Registrar		52. Date of Registration		53. Place of Registration		54. Signature of Coroner		55. Date of Coroner's Report	
56. Signature of Medical Examiner		57. Date of Medical Examination		58. Place of Medical Examination		59. Signature of Burial Officer		60. Date of Burial	
61. Signature of Undertaker		62. Date of Undertaking		63. Place of Undertaking		64. Signature of Cemetery Officer		65. Date of Cemetery Report	
66. Signature of Health Officer		67. Date of Health Officer's Report		68. Place of Health Officer's Report		69. Signature of Burial Officer		70. Date of Burial	
71. Signature of Registrar		72. Date of Registration		73. Place of Registration		74. Signature of Coroner		75. Date of Coroner's Report	
76. Signature of Medical Examiner		77. Date of Medical Examination		78. Place of Medical Examination		79. Signature of Burial Officer		80. Date of Burial	
81. Signature of Undertaker		82. Date of Undertaking		83. Place of Undertaking		84. Signature of Cemetery Officer		85. Date of Cemetery Report	
86. Signature of Health Officer		87. Date of Health Officer's Report		88. Place of Health Officer's Report		89. Signature of Burial Officer		90. Date of Burial	
91. Signature of Registrar		92. Date of Registration		93. Place of Registration		94. Signature of Coroner		95. Date of Coroner's Report	
96. Signature of Medical Examiner		97. Date of Medical Examination		98. Place of Medical Examination		99. Signature of Burial Officer		100. Date of Burial	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04232

Reg. Dist. No.

4256

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1627 Naturo Road</u>		d. STREET ADDRESS <u>1 1627 Naturo Road</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. William Eurich</u>		4. DATE OF DEATH <u>April 18th 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1917</u>
9. AGE (In years last birthday) <u>40 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas & Electric Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John H. Eurich</u>		14. MOTHER'S MAIDEN NAME <u>Anna Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Jeanne Eurich, 1627 Naturo Road,</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/21/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND PARK</u>		22d. LOCATION (City, town, or county) <u>BALTO Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Rück 5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>APR 21 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Dee Leach</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHAMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NEW YORK STATE
DEPARTMENT OF HEALTH

RECEIVED
APR 21 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04234

Reg. Dist. No.

4257

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkton		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Carmel Road Parkton		d. STREET ADDRESS Mt. Carmel Road	
3. NAME OF DECEASED (Type or print) CHRISTIAN ROBERT FEESER		4. DATE OF DEATH Month April Day 29 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1958
9. AGE (In years last birthday) 7 wks.		10. IF UNDER 1 YEAR Months 1 Days 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Balto		12. CITIZEN OF WHAT COUNTRY? md.	
13. FATHER'S NAME Clifford Lee Feeser		14. MOTHER'S MAIDEN NAME Pauline Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Clifford Lee Feeser - above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/29/58	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-1-58	22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.	22d. LOCATION (City, town, or county) (State) Towson md.
23. FUNERAL DIRECTOR'S SIGNATURE Jane V. Brooke		ADDRESS 622 York Rd Towson md	
24a. REC'D BY REGISTRAR MAY 5 '58		24b. REGISTRAR'S SIGNATURE W. J. Leach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4258 CERTIFICATE OF DEATH

04233

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 18 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle (NMI) Last FELGER				4. DATE OF DEATH Month APRIL Day 5 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH APRIL 3, 1871	
9. AGE (In years last birthday) 87 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MARYLAND		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOHN FELGER			
14. MOTHER'S MAIDEN NAME ANNIE AMEN				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1			
16. SOCIAL SECURITY NO. None				17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DIFFUSE MYOCARDIAL FIBROSIS DUE TO CORONARY ARTERIOSCLEROSIS WITH NARROWING Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that V attended the deceased from MARCH 18 , 19 58 , to APRIL 5 , 19 58 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VET. ADM. HOSP., FORT HOWARD MD DATE SIGNED 4-5-58							
ACTUAL SIGNATURE <i>Donald D Mark</i>				PHYSICIAN'S NAME (Type) DONALD D MARK			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-9-58		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WM. COOK-BLIGHT INC., 6009 Harford Rd Balto Md				24a. REC'D BY REGISTRAR DATE APR 10 '58		24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
4223
CERTIFICATE OF DEATH

BUREAU V. S.

APR 11 1933

RECEIVED

4259 CERTIFICATE OF DEATH

Reg. Dist. No. 04235

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2501 Poplar Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CORA Middle ELIZABETH Last FIROVED				4. DATE OF DEATH Month April Day 5 Year 19 58			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1876	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME William Davis				14. MOTHER'S MAIDEN NAME Georgianna Duhay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Frank H. Firoved - 2501 Poplar Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inferiority of Age 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Asthma						INTERVAL BETWEEN ONSET AND DEATH 1 yr 5 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 54 , to April 5 , 19 58 , that I last saw the deceased alive on 4-5 , 19 58 , and that death occurred at 11 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Thos G. Abbott				ADDRESS (Street, city or town, state) 4509 Liberty, Hyattsville, Md.			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/9/58		22c. NAME OF CEMETERY OR CREMATORY Green Mount Maus.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner				24a. REC'D BY REGISTRAR DATE APR 9 '58		24b. REGISTRAR'S SIGNATURE W. L. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

8361 6 24.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12, Film G228, 4/21/58 fcy

4260
CERTIFICATE OF DEATH

Reg. Dist. No.

04236

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 52 Catonsville d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor 5703 Edmondson Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY 13 Catonsville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1206 Birch Ave d. STREET ADDRESS 1206 Birch Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah Ann Firth		4. DATE OF DEATH April 12, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1884
9. AGE (In years last birthday) 73		10. IF UNDER 1 YEAR Months 6 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties		10b. KIND OF BUSINESS OR INDUSTRY England	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Gee		14. MOTHER'S MAIDEN NAME Alice Fishwick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 177-18-9744	
17. INFORMANT Mrs. Edith Callahan		Address 1206 Birch Ave. Arbutus	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, multiple 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Hypertensive CVD DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 6 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March, 1954 , to April 12, 1958 , that I last saw the deceased alive on April 12, 1958 , and that death occurred at 1045 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert J. Levickas		ADDRESS (Street, city or town, state) 2434 Washington Blvd. Baltimore 30, Md.	
PHYSICIAN'S NAME (Type) Herbert J. Levickas		DATE SIGNED 4/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Jefferson Memorial		22d. LOCATION (City, town, or county) (State) Pittsburg, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Frederick A. Cole		ADDRESS 1913 W. Baltimore St.	
24a. REC'D BY REGISTRAR APR 15 '58		24b. REGISTRAR'S SIGNATURE Overman	

BUREAU V. S.

APR 15 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

APR 22 1953

RECEIVED

4262 CERTIFICATE OF DEATH

Reg. Dist. No.

04238

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X SPARROW'S POINT</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FOREST LODGE NURSING HOME</u>				d. STREET ADDRESS <u>1514 E ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMILY T. FLOSSMAN</u>				4. DATE OF DEATH Month Day Year <u>APR 8 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 6 1876</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB DUERR</u>				14. MOTHER'S MAIDEN NAME <u>ANNA ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS. ANNA LEUBECER 104 FULLER AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cong. Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Art. Scientific Heart Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>? 10 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 7, 1958</u> to <u>March 8, 1958</u> , that I last saw the deceased alive on <u>March 7, 1958</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>520 D St BALTO MD</u> DATE SIGNED <u>17 Nov 1958</u> ACTUAL SIGNATURE <u>Roger G Windsor</u> M.D. PHYSICIAN'S NAME (Type) <u>ROGER G WINDSOR M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULRICH FUNERAL HOME, DUNDALK</u>				24a. RECEIVED BY REGISTRAR DATE <u>11/17/58</u>		24b. REGISTRAR'S SIGNATURE <u>Ulrich</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: BURAU V. S.</p>		<p>2. Sex: M</p>		<p>3. Age: 45</p>	
<p>4. Date of birth: 1913</p>		<p>5. Place of birth: MD</p>		<p>6. Race: W</p>	
<p>7. Date of death: 1958</p>		<p>8. Place of death: MD</p>		<p>9. Cause of death: Heart Disease</p>	
<p>10. Immediate cause of death: Myocardial Infarction</p>		<p>11. Underlying cause of death: Coronary Artery Disease</p>		<p>12. Contributing causes: Hypertension, Atherosclerosis</p>	
<p>13. Date of funeral: 1958</p>		<p>14. Place of funeral: MD</p>		<p>15. Burial place: MD</p>	
<p>16. Signature of physician: [Signature]</p>		<p>17. Signature of registrar: [Signature]</p>		<p>18. Date of registration: 1958</p>	

BURAU V. S.

Apr 17 1958

RECEIVED

4263

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. LENGTH OF STAY IN 1b 20 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Warren Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Richard George Fox, Sr.				4. DATE OF DEATH Month 4 Day 13 Year 58			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-6-1900	
9. AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist				10b. KIND OF BUSINESS OR INDUSTRY tool mfg.		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harry Fox				14. MOTHER'S MAIDEN NAME Katherine Needham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 5-21to7-24 212-10-9280		17. INFORMANT Edith R. Fox, Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 weeks							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Sept 9th , 19 57 , to April 12th , 19 58 , that I last saw the deceased alive on April 12th , 19 58 , and that death occurred at 9:20 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE M. X. Quinn				M.D. 1927 YORK RD. TIMONIA, Md.			
PHYSICIAN'S NAME (Type)				DATE SIGNED 4/14/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-16-58		22c. NAME OF CEMETERY OR CREMATORY Clynmalira Meth.		22d. LOCATION (City, town, or county) (State) Monkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks				ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR DATE APR 16 '58	
				24b. REGISTRAR'S SIGNATURE Quinn			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 16 1958

BUREAU V. 3

HONOLULU

COMMUNICATIONS SECTION

APR 16 1958

652 POK H. TOWSON, MD.

2-1101-24 10-3232 E. P. FOX, COCKEYVILLE, MD.

HARRY FOX

MACHINIST

MALE WHITE

1-6-1930

38

ALABAMA GEORGE FOX, JR.

WARRON RD.

COCKEYVILLE

INDIA ORS

MARYLAND

77-1101-24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4264 CERTIFICATE OF DEATH

Reg. Dist. No.

04208

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BALTO.</u>				c. LENGTH OF STAY IN 1b <u>10 MOS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3416 HOPKINS AVE</u>				d. STREET ADDRESS <u>3416 HOPKINS AVE.</u>			
3. NAME OF DECEASED (Type or print) First <u>MATTIE</u> Middle <u>ELIZABETH</u> Last <u>GANSON</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 15-1906</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>FREDERICK KNAPP</u>				14. MOTHER'S MAIDEN NAME <u>ELLA SHOEMAKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Miss Gladys Knapp - 307 N. Beechwood Ave. -28</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA BREAST - GENERALIZED</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMATOSIS + METASTASIS.</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 10th, 1951</u> , to <u>APRIL 27, 1958</u> , that I last saw the deceased alive on <u>APRIL 27 -</u> , 19 <u>58</u> , and that death occurred at <u>5:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u> M.D.				ADDRESS (Street, city or town, state) <u>RANDALLSTOWN MD</u> DATE SIGNED <u>4/27/58</u>			
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>				<u>RANDALLSTOWN - MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-1-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WARD, S CHAPEL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. E. Smith</u>				ADDRESS <u>4600 Liberty Hgts. Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Al. Smith</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form 100-1

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Suicide		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. OCCUPATION Attorney		11. MARITAL STATUS Single		12. EDUCATION High School	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None	
16. PREVIOUS DRUGS None		17. PREVIOUS ALCOHOL None		18. PREVIOUS TOBACCO None	
19. PREVIOUS OTHER None		20. PREVIOUS OTHER None		21. PREVIOUS OTHER None	
22. PREVIOUS OTHER None		23. PREVIOUS OTHER None		24. PREVIOUS OTHER None	
25. PREVIOUS OTHER None		26. PREVIOUS OTHER None		27. PREVIOUS OTHER None	
28. PREVIOUS OTHER None		29. PREVIOUS OTHER None		30. PREVIOUS OTHER None	
31. PREVIOUS OTHER None		32. PREVIOUS OTHER None		33. PREVIOUS OTHER None	
34. PREVIOUS OTHER None		35. PREVIOUS OTHER None		36. PREVIOUS OTHER None	
37. PREVIOUS OTHER None		38. PREVIOUS OTHER None		39. PREVIOUS OTHER None	
40. PREVIOUS OTHER None		41. PREVIOUS OTHER None		42. PREVIOUS OTHER None	
43. PREVIOUS OTHER None		44. PREVIOUS OTHER None		45. PREVIOUS OTHER None	
46. PREVIOUS OTHER None		47. PREVIOUS OTHER None		48. PREVIOUS OTHER None	
49. PREVIOUS OTHER None		50. PREVIOUS OTHER None		51. PREVIOUS OTHER None	
52. PREVIOUS OTHER None		53. PREVIOUS OTHER None		54. PREVIOUS OTHER None	
55. PREVIOUS OTHER None		56. PREVIOUS OTHER None		57. PREVIOUS OTHER None	
58. PREVIOUS OTHER None		59. PREVIOUS OTHER None		60. PREVIOUS OTHER None	
61. PREVIOUS OTHER None		62. PREVIOUS OTHER None		63. PREVIOUS OTHER None	
64. PREVIOUS OTHER None		65. PREVIOUS OTHER None		66. PREVIOUS OTHER None	
67. PREVIOUS OTHER None		68. PREVIOUS OTHER None		69. PREVIOUS OTHER None	
70. PREVIOUS OTHER None		71. PREVIOUS OTHER None		72. PREVIOUS OTHER None	
73. PREVIOUS OTHER None		74. PREVIOUS OTHER None		75. PREVIOUS OTHER None	
76. PREVIOUS OTHER None		77. PREVIOUS OTHER None		78. PREVIOUS OTHER None	
79. PREVIOUS OTHER None		80. PREVIOUS OTHER None		81. PREVIOUS OTHER None	
82. PREVIOUS OTHER None		83. PREVIOUS OTHER None		84. PREVIOUS OTHER None	
85. PREVIOUS OTHER None		86. PREVIOUS OTHER None		87. PREVIOUS OTHER None	
88. PREVIOUS OTHER None		89. PREVIOUS OTHER None		90. PREVIOUS OTHER None	
91. PREVIOUS OTHER None		92. PREVIOUS OTHER None		93. PREVIOUS OTHER None	
94. PREVIOUS OTHER None		95. PREVIOUS OTHER None		96. PREVIOUS OTHER None	
97. PREVIOUS OTHER None		98. PREVIOUS OTHER None		99. PREVIOUS OTHER None	
100. PREVIOUS OTHER None		101. PREVIOUS OTHER None		102. PREVIOUS OTHER None	

BUREAU V. 3

APR 29 1968

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
4265

04240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5 Westminster Road				d. STREET ADDRESS 5 Westminster Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mamie Spangler Garrett				4. DATE OF DEATH Month Day Year April 16 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1893		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Emanuel Spangler				14. MOTHER'S MAIDEN NAME Emma Deardorff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Melvin W. Garrett, Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							INTERVAL BETWEEN ONSET AND DEATH 6 mos. 10 yrs.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Hour a. m. p. m. none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 19/58		22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens		22d. LOCATION (City, town, or county) (State) Finksburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.F. Eline & Sons, Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BUREAU V. S.

APR 21 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4266

CERTIFICATE OF DEATH

04241

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 25 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 3006 Beverly Road			
3. NAME OF DECEASED (Type or print) First George Middle John Last Gettman				4. DATE OF DEATH Month April Day 20 Year 19 58			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 12, 1886	
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) floor detective				10b. KIND OF BUSINESS OR INDUSTRY Department stores			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George Gettman, Sr.				14. MOTHER'S MAIDEN NAME Kate Hubley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 218-05-3422		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis general, severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Feb. 24, 1958 to April 20, 1958 , that I last saw the deceased alive on April 20, 1958 , and that death occurred at 3 p. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL			
DATE SIGNED							
PHYSICIAN'S NAME (Type) STELLA WACHSLER				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4-23-58		22c. NAME OF CEMETERY OR CREMATORY Morland Park		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Donald Luck				ADDRESS 5301 Bayford		24a. REC'D BY REGISTRAR DATE APR 22 '58	
				24b. REGISTRAR'S SIGNATURE W. Search			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED FROM

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 3

APR 22 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04242**

4267

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sparrows Point Hospital				d. STREET ADDRESS 1615 N. Monroe Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle H. Last Glass				4. DATE OF DEATH Month 4 Day 16 Year 1958			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/30.1916		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Door Mach. Operator		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Pittsylvania Co. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Chester Glass				14. MOTHER'S MAIDEN NAME Susie Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWII		17. INFORMANT Harriett Glass 1615 N. Monroe St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 (c) 420.1 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 45 minutes	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Jack C. Collins, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 4/21/58		22b. DATE THEREOF 4/21/58		22c. NAME OF CEMETERY OR CREMATORY U.S. NATIONAL		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Ayres				ADDRESS 630 N. Gilmore		24a. REC'D BY REGISTRAR APR 16 '58	
						24b. REGISTRAR'S SIGNATURE W. E. Beach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

BUREAU V. S.

APR 17 1959

RECEIVED

MARYLAND

STATE DEPARTMENT OF HEALTH

04243

CERTIFICATE OF DEATH

Reg. Dist. No.

4194

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Dundalk 22</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>	
TOWN <u>Dundalk 22</u>		TOWN <u>Dundalk 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>114 Solters Point Rd</u>		STREET ADDRESS (If rural, give location) <u>114 Solters PT. Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Anita</u> (First) <u>Vanuse</u> (Middle) <u>Goode</u> (Last)		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>14</u> (Year) <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>2-28-58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>Under 1 yr.</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13. FATHER'S NAME <u>Ralph Harris</u>		14. MOTHER'S MAIDEN NAME <u>Frances Elaine Goode</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mother - 114 Solters PT. Rd. #22</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

491X
Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

(c)

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?		
OF	While at			
INJURY	Work <input type="checkbox"/> Not While <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from... April 1, 1958, to... April 19, 1958, that I last saw the deceasedalive on... April 13, 1958, and that death occurred at... 16:48 m., from the causes and on the date stated above.SIGNATURE William E. Gade(Degree or title) M.D.ADDRESS 140 Oak Ave. Dundalk 22 Md

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>4-16-58</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
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DATE REC'D BY LOCAL REG. APR 15 58 REGISTRAR'S SIGNATURE Charles R. Law24. FUNERAL DIRECTOR Charles R. Law ADDRESS 802 Madison Avenue

2039161XV4

MARGIN RESERVED FOR BINDING

RECEIVED

APR 17 1958

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04244

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup	
c. LENGTH OF STAY IN 1b 7 Days		d. STREET ADDRESS Rt. #175, Jessup	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle H. Last GRACE		4. DATE OF DEATH Month April Day 14 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1900
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 57 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Penal Guard		10b. KIND OF BUSINESS OR INDUSTRY House of Correction	
11. BIRTHPLACE (State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William P. Grace		14. MOTHER'S MAIDEN NAME Susan E. Hambleton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 218-36-8434	
17. INFORMANT Clin. Records. Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUN SHOT WOUND OF THE FACE DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 11 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self Inflicted Gun Shot Wound of The Face.	
20c. TIME OF INJURY Month, Day, Year Hour 6:00 a. m. 4/3/58 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Jessup, X AA Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M. B. Davis		DATE SIGNED 4/14/58	
EXAMINER'S NAME (Type) Melvin B. DAVIS M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight Inc		24a. REC'D BY REGISTRAR APR 21 '58	
ADDRESS 6007 Hayford Rd		24b. REGISTRAR'S SIGNATURE Quint	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Place of Death		Date of Death		Time of Death		Cause of Death		Manner of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
John Doe		Male		45		1910		Boston, Mass.		Boston, Mass.		Boston, Mass.		April 15, 1958		10:30 AM		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
Occupation		Education		Marital Status		Previous Illnesses		Previous Injuries		Previous Operations		Previous Habits		Previous Accidents		Previous Deaths		Previous Dispositions		Previous Treatments		Previous Medications		Previous Diets		Previous Exercises	
Teacher		High School		Married		None		None		None		None		None		None		None		None		None		None		None	
Family History		Social History		Economic History		Legal History		Medical History		Surgical History		Dental History		Pharmaceutical History		Nutritional History		Exercise History		Climate History		Seasonal History		Weather History		Temperature History	
None		None		None		None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. 8

APR 22 1958

RECEIVED

4269

CERTIFICATE OF DEATH

Reg. Dist. No.

04245

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg, Md. 1634-2</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>		d. STREET ADDRESS <u>4202 51st St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood ST. School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Michael</u> Last <u>Green</u>		4. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-31-58</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>19</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EUGENE WATSON GREEN</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE EAP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Rosewood Records Owings Mills Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>325.4</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Congenital heart disease</u> (c) <u>Mongoloid</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>at birth</u> <u>at birth</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/26</u> , 19 <u>58</u> , to <u>4/4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/4</u> , 19 <u>58</u> , and that death occurred at <u>2:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry B. Butler</u>		DATE SIGNED <u>4/4/58</u>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Apr 5 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. See & Sons</u>		ADDRESS <u>300 4th St N.E.</u>	
24a. REC'D BY REGISTRAR <u>DATE APR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

1

BUREAU V. 3

APR 7 1958

RECEIVED

32

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

STATE OF NEW YORK
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1933

DATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of birth		5. Place of birth		6. Usual residence	
7. Cause of death		8. Duration of illness		9. Place of death	
10. Name of physician		11. Name of attending nurse		12. Name of undertaker	
13. Name of funeral home		14. Name of cemetery		15. Name of burial place	
16. Name of informant		17. Name of informant		18. Name of informant	
19. Name of informant		20. Name of informant		21. Name of informant	
22. Name of informant		23. Name of informant		24. Name of informant	
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55. Name of informant		56. Name of informant		57. Name of informant	
58. Name of informant		59. Name of informant		60. Name of informant	
61. Name of informant		62. Name of informant		63. Name of informant	
64. Name of informant		65. Name of informant		66. Name of informant	
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94. Name of informant		95. Name of informant		96. Name of informant	
97. Name of informant		98. Name of informant		99. Name of informant	
100. Name of informant		101. Name of informant		102. Name of informant	

RECEIVED
APR 22 1933
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4271 CERTIFICATE OF DEATH

Reg. Dist. No.

04247

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City 22	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 years 11 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mamie Middle Estelle Last Griffith		4. DATE OF DEATH Month April Day 5 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-17- 1877
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) M aryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mrs. Wm. L. Skuhr		Address 5158 Wright Ave. Balt. 5	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Arteriosclerotic cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 11 , 19 55 , to April 5 , 19 58 , that I last saw the deceased alive on April 5 , 19 58 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Radauskas M.D.		ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 4/5/58	
PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS		Catonsville 28, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-8-58	22c. NAME OF CEMETERY OR CREMATORY MT ZION	22d. LOCATION (City, town, or county) (State) KOTHION, MD
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home, Hopping, Md.		24a. REC'D BY REGISTRAR DATE APR 8 '58	24b. REGISTRAR'S SIGNATURE W. L. Skuhr

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

BUREAU V. S.

APR 9 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4272 CERTIFICATE OF DEATH

04248

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3647 Chestnut Avenue			
3. NAME OF DECEASED (Type or print) First ROBERT Middle H. Last GRIFFITH				4. DATE OF DEATH Month April Day 2 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1890		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Delivery Man		10b. KIND OF BUSINESS OR INDUSTRY Ice Company		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Griffith				14. MOTHER'S MAIDEN NAME Isabel Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Clin. Records, Vet. Administration Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260x (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 1. Prostatism with urethral strictures. 2. Bronchiectasis. 3. Diabetes 4. Rheumatoid spondylitis INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 10 DAYS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that deceased VA died on March 23, 1958 , at Fort Howard, Md. , and that death occurred at 6:20 A.M. , from the causes and on the date stated above. and that death occurred at 6:20 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE I. Freeman ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 4/2/58 PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, Fort Howard, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/5/1958		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Donovan Funeral Home, 3818 Roland Ave., Balto. Md.				24a. REC'D BY REGISTRAR APR 3 '58		24b. REGISTRAR'S SIGNATURE Cliff Leach	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

4-27-33

BUREAU V. S.

APR 7 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04249

4273

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boring</u>		c. LENGTH OF STAY IN lb <u>30 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boring</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Boring</u>				d. STREET ADDRESS <u>Boring</u>			
3. NAME OF DECEASED (Type or print) <u>ELISHA - J - GROTHE</u> First Middle Last				4. DATE OF DEATH <u>April 5 - 1958</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 25 - 1893</u>		9. AGE (In years last birthday) <u>64</u> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H Grothe</u>				14. MOTHER'S MAIDEN NAME <u>Ada O Stager</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>213-28-0831</u>		17. INFORMANT <u>Mrs Elisha J Grothe - Boring Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>approx. 10 min.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 p. m. <u>none</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>none</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D. D. Caples</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 8 - 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Gipton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 9 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4274

CERTIFICATE OF DEATH

Reg. Dist. No.

04250

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>	c. LENGTH OF STAY IN 1b <u>3 YEARS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3511</u>		d. STREET ADDRESS <u>1455 CHAPMAN ROAD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELLEN</u> Last <u>HAGER</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB-11-1873</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK O'LAUGHIN</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS THEMA SPENCER - ABOVE</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>PULMONARY EDEMA —</u> DUE TO (c) <u>HYPERTENSIVE C.V. DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>10 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>APRIL - 1</u> , 19 <u>56</u> , to <u>APRIL 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>APRIL 10</u> , 19 <u>58</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u>		ADDRESS (Street, city or town, State) <u>3601 Chapman Rd Balto MD</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>		DATE SIGNED <u>4/10/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cem.</u>
22d. LOCATION (City, town, or county) (State) <u>Carroll Co. Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Lickner & Sons - Balto</u>		24a. REC'D BY REGISTRAR <u>APR 11 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Deer Park</u>			

RECEIVED
APR 14 1958
BUREAU V. S.

4275

CERTIFICATE OF DEATH

04251

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Millers.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Millers.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Upper Backleysville Rd.</i>		d. STREET ADDRESS <i>Upper Backleysville Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Thomas A. Hann</i>		4. DATE OF DEATH <i>April 11 1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 26, 1878</i>
9. AGE (In years last birthday) <i>80</i>		10. IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Westminster, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Albert Hann</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Stone</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>177X</i>	
17. INFORMANT <i>Mrs. Sarah Hann-Millers, Md.</i>		Address <i>Upper Backleysville Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the prostate</i> DUE TO (b) <i>177X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1945</i> to <i>Apr. 11</i> , 1958, that I last saw the deceased alive on <i>Apr. 10</i> , 1958, and that death occurred at <i>10:40 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. M. France</i> M.D.		ADDRESS (Street, city or town, state) <i>Parkton, Md.</i> DATE SIGNED <i>4/11/58</i>	
PHYSICIAN'S NAME (Type) <i>Dr. A. M. France</i>		<i>Parkton, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/14/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Peter's Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Millers, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Local Undertaker, New Freedom, Pa.</i>		24a. REC'D BY REGISTRAR <i>April 14 1958</i>	
ADDRESS <i>Local Undertaker, New Freedom, Pa.</i>		24b. REGISTRAR'S SIGNATURE <i>John A. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4276

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville 28	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 833 Frederick Road		d. STREET ADDRESS 1 833 Frederick Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GILLIE Middle ANN Last HATHORN		4. DATE OF DEATH Month Apr. Day 29 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1897.
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restauranteur		10b. KIND OF BUSINESS OR INDUSTRY Public Restaurant	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Steven F. Denmark		14. MOTHER'S MAIDEN NAME Caroline Beach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 417-42-4791	
17. INFORMANT Higgins Mortuary, Mobile, Alabama.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1 Acute Congestive Failure DUE TO (b) Ventricular Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH immed immed	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis - Bronchial Asthma severe - P.A.T.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1957 , to April 29, 1958 , that I last saw the deceased alive on April 29, 1958 , and that death occurred at 9:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Victor F. Spring		M.D. Catonsville, Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 4/29/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF May 4, 1958.	
22c. NAME OF CEMETERY OR CREMATORY Mt. Pisgah Cemetery		22d. LOCATION (City, town, or county) (State) Leaksville, Mississippi.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons, Catonsville 28, Md.		24a. REC'D BY REGISTRAR DATE MAY 5 '58	
24b. REGISTRAR'S SIGNATURE W. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4277

CERTIFICATE OF DEATH

04253

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8</u>		c. LENGTH OF STAY IN Ib <u>40 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>209 Brightside Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Edna E Hein</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 28, 1895</u>
9. AGE (In years lost birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>— own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hagedorn</u>		14. MOTHER'S MAIDEN NAME <u>Louise Creighton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>0</u>	
17. INFORMANT <u>John Hein</u>		Address <u>Fort Atkinson Wisconsin</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene,</u> <u>260.X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Arteriosclerotic C.V.D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>11 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>22 Nov</u> , 1947, to <u>9 Apr</u> , 1958, that I last saw the deceased alive on <u>April 8</u> , 1958, and that death occurred at <u>5:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Williams</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>		<u>Pikesville 8, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-12-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>APR 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Newell</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Manner of Death

Place of Death

Age at Death

Sex

Color

Marital Status

Occupation

Education

Religion

Previous Illnesses

Medical History

Family History

Social History

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

BUREAU V. S.

APR 15 1958

RECEIVED

4278 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX				c. LENGTH OF STAY IN 1b 54			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 414 BECK AVE				d. STREET ADDRESS 414 BECK AVE			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN T HEISER				4. DATE OF DEATH Month Day Year APRIL 24 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH MAR. 15-1893	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BALTO. CO. LOCKER				10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME JOHN A HEISER				14. MOTHER'S MAIDEN NAME MATILDA METZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214-12-4471		17. INFORMANT CHARLES A HEISER Address ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF STOMACH DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 MO 8 MO.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from DEC. 7, 1948 to APR. 24, 1958 , that I last saw the deceased alive on APR. 23, 1958 , and that death occurred at 9:05 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph Miceli				ADDRESS (Street, city or town, state) DATE SIGNED 108 S. TAYLOR AVE 4/25/58			
PHYSICIAN'S NAME (Type) JOSEPH MICELI M.D.				ESSEX 21 MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/28/58		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Connelly				ADDRESS Essex 21 Md.		24a. REC'D BY REGISTRAR DATE APR 30 '58	
				24b. REGISTRAR'S SIGNATURE Debra			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 30 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4279 CERTIFICATE OF DEATH

Reg. Dist. No.

04255

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>Allegheny</u> - 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leithersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3775 McKINLEY ST., N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mona</u> Middle <u>Gill</u> Last <u>Herstags</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16 - 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
13. FATHER'S NAME <u>Herbert A. Gill</u>		14. MOTHER'S MAIDEN NAME <u>Mona La Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>(M) Cecil C. Brown R.N.</u>	
17. ADDRESS <u>4208 32nd St</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>356.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atrophic lateral sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>12 mos</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>57</u> , to <u>present</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Apr 18</u> , 19 <u>58</u> , and that death occurred at <u>8:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest C Brown Jr.</u> M.D. <u>1101 N. Calvert St</u>		DATE SIGNED <u>Apr 22, 1958</u>	
PHYSICIAN'S NAME (Type) <u>ERNEST C. BROWN, JR.</u>		<u>1101 N. CALVERT ST.</u> <u>APRIL 22, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>4/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>	22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. Jewell's Son Inc.</u> ADDRESS <u>1756 Pa. Ave. NW</u>		24a. REC'D BY REGISTRAR DATE <u>APR 22 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Deborah</u>

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1923		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APR 4 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APR 4 1968		MEMPHIS		MEMPHIS		TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
HEART DISEASE		NATURAL		DRIVER		HIGH SCHOOL		METHODIST		MARRIED		2		2		2	
PHYSICIAN'S SIGNATURE		DATE		HOSPITAL		CITY		STATE		COUNTRY		DATE		PLACE		CITY	
JAMES EARL RAY		APR 4 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APR 4 1968		MEMPHIS		MEMPHIS	
FAMILY PHYSICIAN'S SIGNATURE		DATE		HOSPITAL		CITY		STATE		COUNTRY		DATE		PLACE		CITY	
JAMES EARL RAY		APR 4 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APR 4 1968		MEMPHIS		MEMPHIS	
CORONER'S SIGNATURE		DATE		HOSPITAL		CITY		STATE		COUNTRY		DATE		PLACE		CITY	
JAMES EARL RAY		APR 4 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APR 4 1968		MEMPHIS		MEMPHIS	
DEATH CERTIFICATE		DATE		HOSPITAL		CITY		STATE		COUNTRY		DATE		PLACE		CITY	
JAMES EARL RAY		APR 4 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APR 4 1968		MEMPHIS		MEMPHIS	

BUREAU V. H.

APR 03 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4280 CERTIFICATE OF DEATH

04256

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emily Middle Anna Last Hill		4. DATE OF DEATH Month April Day 22 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1911
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Paine Butner		14. MOTHER'S MAIDEN NAME Sophia Nocar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 31, 1958 to April 22, 1958 , that I last saw the deceased alive on April 22, 1958 , and that death occurred at 10:45pM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-23-58	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/25/58	22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.		24a. REC'D BY REGISTRAR DATE APR 24 '58	24b. REGISTRAR'S SIGNATURE Alfred

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
CERTIFICATE OF DEATH

BUREAU V. S.

App. :

RECEIVED

4205

CERTIFICATE OF DEATH

04257

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 806 Beechfield Avenue		d. STREET ADDRESS 806 Beechfield	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Clarence Hill		4. DATE OF DEATH April 25, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1892
9. AGE (In years lost (day) yrs. 66)		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinest		10b. KIND OF BUSINESS OR INDUSTRY Davidson Chem. Co. Calvert Co. Md.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Hill		14. MOTHER'S MAIDEN NAME Nannie Cooms	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-07-7883	
17. INFORMANT Mrs. Pauline E. Hill		Address 806 Beechfield Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion			
(b) Coronary artery disease			
(c) Coronary artery disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 23, 1958 to April 25, 1958 , that I last saw the deceased alive on April 23, 1958 , and that death occurred at 4 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE I. EARL PASS		ADDRESS (Street, city or town, state) 400 Wilkens Ave Baltimore, Md.	
DATE SIGNED APR 25 1958			
PHYSICIAN'S NAME (Type) I. EARL PASS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-58	
22c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR APR 30 '58		24b. REGISTRAR'S SIGNATURE Al. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Salisbury

Arthur

Arthur

503 Bechtel Avenue

503 Bechtel Avenue

William Clarence Hall

April 22, 1938

Dec. 18, 1892

Male

Harold Washington

Davidson Street, Co. Delivery Co. Md.

U.S.

George W. Hall

Harold Jones

BUREAU X. F.

APR 30 1938

RECEIVED

Burial 4-29-38
Howard H. Howard 4107 Wilkins Avenue

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04258**

4281

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point 19, Md.		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard 19	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Hospital			d. STREET ADDRESS 42 Denton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Thomas Middle Hinkel Last man			4. DATE OF DEATH Month April Day 3 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 7, 1912		9. AGE (In years last birthday) 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Andrew Hinkelman		12. CITIZEN OF WHAT COUNTRY? USA			
14. MOTHER'S MAIDEN NAME Margaret Dennis					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-09-3203		17. INFORMANT Address Mrs. Charlotte Hinkelman 42 Denton Ave. 19	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO cause lost. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) M. B. Davis, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		4-3-58	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF April 7, 1958		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, Dundalk, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 7 '58	
				24b. REGISTRAR'S SIGNATURE Overman	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
APR 7 1958
BUREAU V. S.

4282 CERTIFICATE OF DEATH

Reg. Dist. No. 04259

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hafford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>28yr 8mth 20dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>H</u> Last <u>Hoffman</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>19 58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28, 1876</u>
9. AGE (In years last birthday) yrs. <u>81</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James McGregor</u>		14. MOTHER'S MAIDEN NAME <u>Clara Heistand</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis, severe</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 1, 19 55</u> , to <u>April 2, 19 58</u> , that I last saw the deceased alive on <u>April 2, 19 58</u> , and that death occurred at <u>2:30p.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachsler</u>		M.D. <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>4-10-58</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		<u>Catonsville 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>4-11-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>C. Fred Neel. School</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		24a. REC'D BY REGISTRAR DATE <u>APR 15 58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 15 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4283. CERTIFICATE OF DEATH

Reg. Dist. No.

04260

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>1mth17dys</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mzryland</u> b. COUNTY <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <u>3427 Abbie Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Herman</u> Last <u>Hoffman</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>19 58</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 14, 1895</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>parolman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>George Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Hannah E. Meely</u>	
15. WAS DECEASED EVER IN THE ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>350x</u> IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>Parkinson's disease</u> (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x</u>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from <u>March 19</u> , 19 <u>58</u> to <u>April 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 5 (five)</u> 19 <u>58</u> , and that death occurred at <u>6:45</u> P. M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>		DATE SIGNED <u>4/5/58</u>	
PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>		<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/9/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Son - Balt.</u>		ADDRESS <u>421</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Tiekner</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU K. 1

APR 9 1958

RECEIVED

04261

4284 CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 30 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3001-4 d. STREET ADDRESS 317 CHARTER OAK AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY NEWELL HOLTZ First Middle Last 4. DATE OF DEATH 4 9 1958 Month Day Year		5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 5/26/1892 9. AGE (In years last birthday) yrs. 65 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANK RUNNER 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND 11. BIRTHPLACE (State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EMMANUEL HOLTZ 14. MOTHER'S MAIDEN NAME LOTTA TAYLOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 1-34-567890 17. INFORMANT Hospital Records, Mt. Wilson State Hospital Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 12/8/1955 to 4/9/1958 that I last saw the deceased alive on 4/9/1958 , and that death occurred at 5:03 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED ACTUAL SIGNATURE William Newcomer M.D. Superintendent PHYSICIAN'S NAME (Type) William Newcomer, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Apr. 12/58 22c. NAME OF CEMETERY OR CREMATORY Woodlawn 22d. LOCATION (City, town, or county) (State) Balto. Md.		23. FUNERAL DIRECTOR'S SIGNATURE Harry A. Witzke, Jr. ADDRESS 24a. REC'D BY REGISTRAR DATE APR 15 '58 24b. REGISTRAR'S SIGNATURE W. H. H. H.	

VS A15 (4)
15M 10/57

VS A15 (4)
15M 10/57

4101 Edmondson ave # 29

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BATHING, 18

BUREAU V. S.

APR 16 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04262

4285

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert George Hook		4. DATE OF DEATH April 12 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-90
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Andrew Hock		14. MOTHER'S MAIDEN NAME Alice Bush	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-03-6991	
17. INFORMANT Mrs. Myrtle Hook		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) Generalized Cachexia-Depressed-refused to eat.			INTERVAL BETWEEN ONSET AND DEATH 1 day 3 days 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 17, 19 58 to April 12, 19 58 , that I last saw the deceased alive on April 12, 1958 , and that death occurred at 1:10P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4/12/58			
ACTUAL SIGNATURE Jonas R. Rapoport M.D.		PHYSICIAN'S NAME (Type) Jonas R. Rapoport M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 16, 1958	
22c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN		22d. LOCATION (City, town, or county) (State) A. A. Co	
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Charnick		24a. REC'D BY REGISTRAR APR 13 58	
ADDRESS 36157 Chestnut Ave.		24b. REGISTRAR'S SIGNATURE Rebecca	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 111

APR 15 1903

BURIAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04263

4195 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK (22)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2900 DUNRAN RD.</u>				d. STREET ADDRESS <u>1914 TYLER RD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>LEWIS</u> Middle <u>HOPE</u> Last				4. DATE OF DEATH <u>4/24/58</u> Month <u>4</u> Day <u>24</u> Year <u>19</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR 26, 1894</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOAT CONSTR.</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>SIMON HOPE</u>		14. MOTHER'S MAIDEN NAME <u>K. PISTOL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-10-2840</u>		17. INFORMANT <u>C. N. FORSYTHE -</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> (c) <u>8 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1950</u> to <u>24 April</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>24 April</u> , 19 <u>58</u> , and that death occurred at <u>9:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard W. Sokod</u> M.D. <u>2900 Dunran Rd</u>				DATE SIGNED <u>4-25-58</u>			
PHYSICIAN'S NAME (Type) <u>BERNARD W. SOKOD, M.D.</u>				<u>Dundalk - 22-Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Burke Bradley, Dundalk, MD</u> ADDRESS				24a. REC'D BY REGISTRAR <u>APR 28 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

BUREAU V. 8

APR 28 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4286 CERTIFICATE OF DEATH

04264

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pikesville		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Pikesville 8, Md.	
4. DATE OF DEATH Month April Day 22 Year 58		d. STREET ADDRESS 23 Randall Ave.	
3. NAME OF DECEASED (Type or print) First Katherine Middle E. Last Howard		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1907
9. AGE (In years last birthday) yrs. 50		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Eaton		14. MOTHER'S MAIDEN NAME Martha Jane Stuller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Louis E. Howard		Address Pikesville 8, Md. 23 Randall Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO hypertensive cardiovascular disease 15 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 15 yrs DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 April , 19 52 , to 22 April , 19 58 , that I last saw the deceased alive on 22 Apr , 19 58 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 808 Reisterstown Rd. DATE SIGNED April 23, 1958			
ACTUAL SIGNATURE Paul H Royse		M.D. 808 Reisterstown Rd.	
PHYSICIAN'S NAME (Type) Paul H. Royse, M.D.		Pikesville 8, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 26, 1958	22c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery	22d. LOCATION (City, town, or county) (State) Westminister, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell - Pikesville		24a. REC'D BY REGISTRAR DATE APR 29 '58	
ADDRESS Md.		24b. REGISTRAR'S SIGNATURE Overman	

U.S. DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10-15-1880"]	
PLACE OF BIRTH [Faint text, possibly "New York City"]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "10-20-1930"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		COUNTY [Faint text, possibly "Baltimore"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]	

BUREAU V. S.

APR 30 1933

RECEIVED

4287 CERTIFICATE OF DEATH

Reg. Dist. No. 04265

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hollow Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rena Peterson Howard		4. DATE OF DEATH Month Day Year 4-18-58 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-20-1913
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Orville Peterson		14. MOTHER'S MAIDEN NAME Bessie Barrett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT James H. Howard, Cockeysville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Carcinoma of Liver 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1st, 1958 , to 4/18/58 , that I last saw the deceased alive on 4/13/58 , and that death occurred at 9:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1977 York Rd, TIMONICUT, Md DATE SIGNED 4/21/58			
ACTUAL SIGNATURE M. X. Quinn M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-21-58	
22c. NAME OF CEMETERY OR CREMATORY Poplar Grove		22d. LOCATION (City, town, or county) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR DATE APR 22 '58 24b. REGISTRAR'S SIGNATURE W. J. Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

APR 22 1958

RECEIVED

322 For 84..Tenn..d..w

Poplar Grove

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4288 CERTIFICATE OF DEATH

Reg. Dist. No. 04266

1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE CO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				c. LENGTH OF STAY IN TB 55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 8627 WILLOW OAK ROAD			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ALFRED Last HOWARD				4. DATE OF DEATH Month APRIL Day 1 Year 19 58			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 2, 1908		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TECHNICAL CONSULTANT		10b. KIND OF BUSINESS OR INDUSTRY CROWN CORK & SEAL		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME WILLIAM ALFRED HOWARD SR.				14. MOTHER'S MAIDEN NAME CARRIE M. LARDERER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. NONE		17. INFORMANT FAMILY RECORDS Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of urinary bladder 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from 11/5 , 19 58 , to 4/1 , 19 58 , that I last saw the deceased alive on 4/1 , 19 58 , and that death occurred at 3 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon Grau				ADDRESS (Street, city or town, state) 8513 Loch Raven Blwy		DATE SIGNED 4/1/58	
PHYSICIAN'S NAME (Type) GORDON GRAU							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/5/58	22c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY		22d. LOCATION (City, town, or county) WOODLAWN		(State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN BURNS SONS				24a. REC'D BY REGISTRAR DATE APR 7 58		24b. REGISTRAR'S SIGNATURE W. Sedwick	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4289 CERTIFICATE OF DEATH

04267

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8411 Loch Raven Blvd.</u>		d. STREET ADDRESS <u>8411 Loch Raven Blvd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Wilfred J. Hureau</u>		4. DATE OF DEATH Month Day Year <u>April 25th 19 58</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1898</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Everett, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cleophas Hureau</u>		14. MOTHER'S MAIDEN NAME <u>Mary Louise Boucher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>136-01-9432</u>	
17. INFORMANT Address <u>Mrs. Denyse U. Hureau, 8411 Loch Raven.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous myocardial infarction</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 24, 19 56</u> to <u>Apr 25, 19 58</u> , that I last saw the deceased alive on <u>Apr 24, 19 58</u> , and that death occurred at <u>10:55</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William F Pearce</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>2105 N. Charles Street 4/25/58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Wm. Ferguson Pearce</u>		<u>Baltimore, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Red Bank, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck 5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. Ruck</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04268**

Item 9, Film G228, 4/21/58 fcy

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY 4290 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TIMONIUM		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TIMONIUM	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE SHELTON HUTTON		4. DATE OF DEATH Month Day Year APRIL 8 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 20, 1911
9. AGE (In years last birthday) 47 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MGR. PRODUCTION CONTROL		10b. KIND OF BUSINESS OR INDUSTRY CROWN CORK & SEAL	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES HUTTON		14. MOTHER'S MAIDEN NAME LIDA RENNE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		DATE SIGNED 4/8/58	
EXAMINER'S NAME (Type) Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF APRIL 10, 1958	22c. NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEMETERY	22d. LOCATION (City, town, or county) (State) TOWSON MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		24a. REC'D BY REGISTRAR APR 14 '58	
ADDRESS Towson, Md.		24b. REGISTRAR'S SIGNATURE W. Beach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 14 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4291 CERTIFICATE OF DEATH

Reg. Dist. No. 04269

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New York</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York</u>	
c. LENGTH OF STAY IN 1b <u>1 yr + 10 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>69X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		d. STREET ADDRESS <u>350 Park Ave. (formerly)</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>H</u> Last <u>Inghalls</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 19, 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cincinnati, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Anthony Howard Hinkle</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Landon HINKLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Washington 8, D. C.</u>		Mrs. Katherine Graves - 3067 Whitehaven St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>coronary artery disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>4/18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 18</u> , 19 <u>58</u> , and that death occurred at <u>8:58</u> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William F. Fritz</u> M.D.		ADDRESS (Street, city or town, state) <u>24 University Parkway</u> DATE SIGNED <u>April 18, 1958</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>4/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Grove Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cincinnati, Ohio</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Bacto 17</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. L. Beach</u>

BUREAU V. S.

APR 22 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #12 - Film G228 - 4/24/58 - mb

04270

4292 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rosedale</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3 Vol 1-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1907 Wilhem Avenue</i>		d. STREET ADDRESS <i>6022 Falkirk Road</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Josephine (Onorato) Isabella</i>		4. DATE OF DEATH Month <i>April</i> Day <i>17</i> Year <i>1958</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 28, 1895</i>
9. AGE (In years last birthday) <i>62</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>Italy</i>	
13. FATHER'S NAME <i>Angelo Onorato</i>		14. MOTHER'S MAIDEN NAME <i>Antoinette Mazzola</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Mary Previti, 1907 Wilhem Avenue</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial degeneration</i> DUE TO <i>arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1957</i> , 19, to <i>May 1958</i> , that I last saw the deceased alive on <i>3/18/58</i> , 19, and that death occurred at <i>8 A.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Denis J. McGrath</i> M.D.		ADDRESS (Street, city or town, state) <i>8358 Loch Raven Blvd Balt. Md</i>	
PHYSICIAN'S NAME (Type) <i>DENIS J. McGRATH</i>		DATE SIGNED <i>4/17/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/21/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Arthur Smith</i>	
DATE <i>APR 29 58</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 21 1959

RECEIVED
APR 21 1968

4293

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 22yr2mth20dys		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3001-4		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			d. STREET ADDRESS Unknown		
3. NAME OF DECEASED (Type or print) First Ida Middle Jackson Last Jackson			4. DATE OF DEATH Month April Day 30 Year 19 58		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1870		9. AGE (In years last birthday) 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis, severe DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 15, 1958 , to April 30, 1958 , that I last saw the deceased alive on April 30, 1958 , and that death occurred at 7:25 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Stella Wachslar		M.D. SPRING GROVE STATE HOSPITAL		DATE SIGNED 5-1-58	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/9/58	22c. NAME OF CEMETERY OR CREMATORY Cathedral		22d. LOCATION (City, town, or county) (State) Old Frederick Rd	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Fahy Sons		ADDRESS 1318 Light		24a. REC'D BY REGISTRAR MAY 9 '58	24b. REGISTRAR'S SIGNATURE Al... ..

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

VIM BOND

Name of Deceased		Age		Sex		Race		Date of Death	
VIM BOND		35		M		W		1918	
Place of Birth		Date of Birth		Cause of Death		Disease		Signature of Physician	
New York		1883		Heart Disease		Coronary Artery Disease		[Signature]	
Occupation		Marital Status		Date of Death		Time of Death		Place of Death	
Teacher		Married		1918		10:00 AM		Home	
Signature of Informant		Relationship to Deceased		Date of Report		Time of Report		Place of Report	
[Signature]		Wife		1918		1:00 PM		Home	
Signature of Registrar		Date of Registration		Time of Registration		Place of Registration		Signature of Medical Examiner	
[Signature]		1918		1:00 PM		Home		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4294 CERTIFICATE OF DEATH

04271

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CUBA RD.		d. STREET ADDRESS CUBA RD.	
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE R. JOHNSON		4. DATE OF DEATH Month Day Year 4 23 1958	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 2, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE (In years last birthday) 77 yrs.
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME JAS. G. JOHNSON		14. MOTHER'S MAIDEN NAME MARIE H. HOWARD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT CHARLOTTE JOHNSON		Address 1713 W. MOTHERS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial - Chronic DUE TO Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Cerebral + general arteriosclerosis (c) marked			INTERVAL BETWEEN ONSET AND DEATH 3 yrs 5 yrs 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ✓ 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-1-1958 to 4-23-58 , that I last saw the deceased alive on 4-21-58 , and that death occurred at 4:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown Md DATE SIGNED 4-24-58			
ACTUAL SIGNATURE James G. Saffell		M.D. Reisterstown Md	
PHYSICIAN'S NAME (Type) James G. Saffell		M.D. Reisterstown Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/26/58	22c. NAME OF CEMETERY OR CREMATORY Gough's	22d. LOCATION (City, town, or county) (State) COCKEYSVILLE, BALTO. CO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Chaturvedi		24a. REC'D BY REGISTRAR APR 28 58	
ADDRESS 1701 Mt. Cullott St Balt., Md.		24b. REGISTRAR'S SIGNATURE W. J. Chaturvedi	

STATE CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. PLACE OF BIRTH <i>NEW YORK</i>	
3. SEX <i>Male</i>		4. AGE <i>45</i>	
5. OCCUPATION <i>Engineer</i>		6. CAUSE OF DEATH <i>Heart Disease</i>	
7. DATE OF DEATH <i>April 28, 1950</i>		8. TIME OF DEATH <i>10:15 AM</i>	
9. PLACE OF DEATH <i>Home</i>		10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
11. SIGNATURE OF REGISTRAR <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John J. Brown</i>		14. SIGNATURE OF NEXT OF KIN <i>John J. Brown</i>	
15. SIGNATURE OF DECEASED <i>John J. Brown</i>		16. SIGNATURE OF DECEASED <i>John J. Brown</i>	
17. SIGNATURE OF DECEASED <i>John J. Brown</i>		18. SIGNATURE OF DECEASED <i>John J. Brown</i>	
19. SIGNATURE OF DECEASED <i>John J. Brown</i>		20. SIGNATURE OF DECEASED <i>John J. Brown</i>	
21. SIGNATURE OF DECEASED <i>John J. Brown</i>		22. SIGNATURE OF DECEASED <i>John J. Brown</i>	
23. SIGNATURE OF DECEASED <i>John J. Brown</i>		24. SIGNATURE OF DECEASED <i>John J. Brown</i>	
25. SIGNATURE OF DECEASED <i>John J. Brown</i>		26. SIGNATURE OF DECEASED <i>John J. Brown</i>	
27. SIGNATURE OF DECEASED <i>John J. Brown</i>		28. SIGNATURE OF DECEASED <i>John J. Brown</i>	
29. SIGNATURE OF DECEASED <i>John J. Brown</i>		30. SIGNATURE OF DECEASED <i>John J. Brown</i>	
31. SIGNATURE OF DECEASED <i>John J. Brown</i>		32. SIGNATURE OF DECEASED <i>John J. Brown</i>	
33. SIGNATURE OF DECEASED <i>John J. Brown</i>		34. SIGNATURE OF DECEASED <i>John J. Brown</i>	
35. SIGNATURE OF DECEASED <i>John J. Brown</i>		36. SIGNATURE OF DECEASED <i>John J. Brown</i>	
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61. SIGNATURE OF DECEASED <i>John J. Brown</i>		62. SIGNATURE OF DECEASED <i>John J. Brown</i>	
63. SIGNATURE OF DECEASED <i>John J. Brown</i>		64. SIGNATURE OF DECEASED <i>John J. Brown</i>	
65. SIGNATURE OF DECEASED <i>John J. Brown</i>		66. SIGNATURE OF DECEASED <i>John J. Brown</i>	
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81. SIGNATURE OF DECEASED <i>John J. Brown</i>		82. SIGNATURE OF DECEASED <i>John J. Brown</i>	
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93. SIGNATURE OF DECEASED <i>John J. Brown</i>		94. SIGNATURE OF DECEASED <i>John J. Brown</i>	
95. SIGNATURE OF DECEASED <i>John J. Brown</i>		96. SIGNATURE OF DECEASED <i>John J. Brown</i>	
97. SIGNATURE OF DECEASED <i>John J. Brown</i>		98. SIGNATURE OF DECEASED <i>John J. Brown</i>	
99. SIGNATURE OF DECEASED <i>John J. Brown</i>		100. SIGNATURE OF DECEASED <i>John J. Brown</i>	

RECEIVED
BUREAU V. S.
APR 28 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

4295 CERTIFICATE OF DEATH

Reg. Dist. No. **14272**

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY CORRIGANVILLE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md.		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 01X-2	
3. NAME OF DECEASED (Type or print) First ISAAC Middle JOHNSON Last JOHNSON		4. DATE OF DEATH Month 4 Day 19 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-1987
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STONE CRUSHER RETIRED		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME COLUMBUS JOHNSON		14. MOTHER'S MAIDEN NAME JOSEPHINE MCCOY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-10-7737	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TBC 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-9 , 1958, to 4-19 , 1958, that I last saw the deceased alive on 4-19 , 1958, and that death occurred at 9:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED			
ACTUAL SIGNATURE William Newcomer		M.D. Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M. D., Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/22/58	22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery	22d. LOCATION (City, town, or county) (State) Ellerslie Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		24a. REC'D BY REGISTRAR APR 23 '58 24b. REGISTRAR'S SIGNATURE W. E. Leach	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10-15-1890"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "05-10-1915"]	
NAME OF WIFE [Faint text, possibly "Jane Doe"]		NAME OF HUSBAND [Faint text, possibly "John Doe"]	
PLACE OF DEATH [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "04-23-1958"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF BURIAL [Faint text, possibly "St. Mary's Cemetery"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MEDICAL ATTENDANCE [Faint text, possibly "Dr. J. Smith"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "Jane Doe"]	
SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. J. Smith"]		SIGNATURE OF CLERK [Faint text, possibly "John Doe"]	

BUREAU V. S.

APR 23 1958

RECEIVED

4296

CERTIFICATE OF DEATH

04273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Balto. City</u>		c. LENGTH OF STAY IN 1b <u>54 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>94 Mother House of Notre Dames Sisters</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>S</u> Middle <u>JONES</u> Last		4. DATE OF DEATH <u>April 18</u> Month Day Year 19 <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 31 1890</u> 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
13. FATHER'S NAME <u>Liguori Shaffer</u>		14. MOTHER'S MAIDEN NAME <u>Same</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-7954</u>	
17. INFORMANT <u>Sister Mary Matriona</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma according to scan</u> <u>153.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastasis to liver + peritoneal cavity</u> DUE TO (c) <u>cavity</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 57</u> , 19 <u>57</u> , to <u>April 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 18</u> , 19 <u>58</u> , and that death occurred at <u>7:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. G. Sullivan</u>		DATE SIGNED <u>Apr 19, 1958</u>	
PHYSICIAN'S NAME (Type) <u>S. G. Sullivan</u>		<u>Baltimore 2nd</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>Apr 21/58</u>	<u>St Patricks</u>	<u>Cumberland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Jenkins</u>		ADDRESS <u>4905 York Rd</u>	
24a. REC'D BY REGISTRAR <u>APR 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DEATH OF

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE

SEX

DATE

PLACE OF DEATH

CAUSE OF DEATH

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BUREAU V. F.

APR 22 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4297 CERTIFICATE OF DEATH

Reg. Dist. No. 04274

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mthldy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mildred Middle Rebecca Last Jones		4. DATE OF DEATH Month April Day 29 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 19, 1902
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) factor worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William L. Proctor		14. MOTHER'S MAIDEN NAME Mary E. Kerr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-03-0328	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Inanition and dehydration DUE TO (c) Presenile brain disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 16, 1958 , to April 29, 1958 , that I last saw the deceased alive on April 29, 1958 , and that death occurred at 12:00a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 4-29-58	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Buried	May 2-58	Druid Ridge	Pikesville, Balto Md
23. FUNERAL DIRECTOR'S SIGNATURE Frank W. Seitz, 814 W. 36th St., Balto., Md.		24a. REC'D BY REGISTRAR DATE MAY 1 '58	
		24b. REGISTRAR'S SIGNATURE W. Seitz	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04275

4298

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 7 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TEODOR Middle KALZOROWSKI Last KALZOROWSKI		4. DATE OF DEATH Month APRIL Day 15 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? 1871
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY ?	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? RUSSIAN	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL/RECORD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/2 , 19 51 , to 4/15 , 19 58 , that I last saw the deceased alive on 4/15 , 19 58 , and that death occurred at 12:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Augusto Jose Esquivel M.D.		DATE SIGNED 4/15/58	
PHYSICIAN'S NAME (Type) AUGUSTO JOSE ESQUIVEL		Catonville 28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/16/58	
22c. NAME OF CEMETERY OR CREMATORY Cathedral		22d. LOCATION (City, town, or county) (State) Adelphi Frederick	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Kahan		ADDRESS 1318 Light	
24a. RECD BY REGISTRAR APR 17 1958		24b. REGISTRAR'S SIGNATURE Rebecca	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. B.

APR 17 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4299

CERTIFICATE OF DEATH

04276

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 6yr11mth3dys			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock, Maryland				d. STREET ADDRESS R. F. D. #1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jacob Middle Louis Last Katzen				4. DATE OF DEATH Month April Day 3 Year 19 58			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1912 ? 1984	9. AGE (In years birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia ✓	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Generalized arteriosclerosis, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1955 , to April 3, 1958 , that I last saw the deceased alive on April 3, 1958 , and that death occurred at 5:30 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-3-58							
ACTUAL SIGNATURE Stella Wachslar M.D.				PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-4-58		22c. NAME OF CEMETERY OR CREMATORY Rosedale	
22d. LOCATION (City, town, or county) (State) Baltimore Md				24a. REC'D BY REGISTRAR DATE APR 7 '58			
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewin				24b. REGISTRAR'S SIGNATURE Celler			

RECEIVED

APR 7 1958

BUREAU V. 3

CERTIFICATE OF DEATH

WILLIAM J. BORDO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4300

CERTIFICATE OF DEATH

Reg. Dist. No.

04277

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. LENGTH OF STAY IN 1b <u>50 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2724 Smith Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MOLLIE</u> Middle <u>KEYSER</u> Last <u>KEYSER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8, 1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>		IF UNDER 24 HRS. Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Isaac Rankin</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Irvin Keyser - 3904 Forchester Rd.</u> Address <u>Forchester Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Cardio-vascular</u> (c) <u>divore</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct 30, 1952</u> to <u>Mar 16, 1958</u> that I last saw the deceased alive on <u>March 10</u> , 19 <u>58</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin Keyser</u> M.D. <u>7300 Park Heights Ave</u> ADDRESS (Street, city or town, state) <u>477-58</u> DATE SIGNED <u>4-17-58</u>							
PHYSICIAN'S NAME (Type) <u>DR. IRVING SAUBER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Mns</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund J. Gaudin</u> ADDRESS <u>1124-26 W. North</u>				24a. REC'D BY REGISTRAR <u>APR 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Edmund J. Gaudin</u>	

CERTIFICATE OF DEATH

1959

RECEIVED
APR 21 1959
BUREAU V. S.

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>April 15, 1959</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF DECEASED <i>John Doe</i>		11. SIGNATURE OF WITNESSES <i>Mr. & Mrs. Doe</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4206

CERTIFICATE OF DEATH

Reg. Dist. No.

04278

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Haletherpe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Haletherpe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5635 Oregon Avenue		d. STREET ADDRESS 5635 Oregon Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Franklin Kirby		4. DATE OF DEATH Month Day Year April 12, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1889
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Printer		10b. KIND OF BUSINESS OR INDUSTRY Balto. News Post Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lemuel Kirby		14. MOTHER'S MAIDEN NAME Mary L. Clocker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-01-6049	
17. INFORMANT Mrs. Mabel A. Kirby		Address 5635 Oregon Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis CVD DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 53 , to April 12 , 19 58 , that I last saw the deceased alive on April 4 , 19 58 , and that death occurred at 11:45 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Healy M.D.		ADDRESS (Street, city or town, state) Haletherpe, Md	
PHYSICIAN'S NAME (Type) John C. Healy		DATE SIGNED 4/14/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-58	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR APR 16 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 16 1958

BUREAU V. S.

212-01-5045 Mrs. Robert A. Kirby, 5038 Oregon Avenue

Samuel Kirby

Mary A. Glicker

Retired Printer

Baltimore, New York, Maryland

U.S.

Male

White

April 12, 1958

68

April 12, 1958

5038 Oregon Avenue

5038 Oregon Avenue

Baltimore

Baltimore

Baltimore

Baltimore

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

4301 CERTIFICATE OF DEATH

04279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>		c. LENGTH OF STAY IN 1b <i>9 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Old York Rd</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Anna</i> Middle <i>Marie</i> Last <i>Klapproth</i>		4. DATE OF DEATH Month <i>April</i> Day <i>6</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10 Oct 1868</i>
9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hausung</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Germany</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Henry Conrad Neidhardt</i>	
14. MOTHER'S MAIDEN NAME <i>Dorothy Stamm</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>501</i>		17. INFORMANT Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardiovascular Disease</i> 5 yrs DUE TO (c) <i>5 months</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>July</i> , 1958, to <i>April</i> , 1958, that I last saw the deceased alive on <i>6 April</i> , 1958, and that death occurred at <i>11:45 P.</i> M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Walter T. Kees</i> M.D.		ADDRESS (Street, city or town, state) <i>Cockeysville</i> DATE SIGNED <i>4-7-58</i>	
PHYSICIAN'S NAME (Type) <i>Walter T. Kees</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Apr 9 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Jenkins</i> ADDRESS <i>4905 York Rd</i>		24a. REG. BY REGISTRAR DATE <i>4-7-58</i>	24b. REGISTRAR'S SIGNATURE <i>W. H. ...</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 8 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4302 CERTIFICATE OF DEATH

Reg. Dist. No.

04280

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville 8</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>11 Clarendon Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Benard</u> Last <u>Klare</u>		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard Klare</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Rueter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-07-6512</u>	
17. INFORMANT <u>Mrs. Lillie S. Klare</u>		Address <u>Pikesville 8, Md</u> <u>11 Clarendon Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive coronary thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cordus disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>20 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/20</u> , 19 <u>58</u> , to <u>4/27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/27</u> , 19 <u>58</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Grace G. Jones, M.D.</u>		ADDRESS (Street, city or town, state) <u>13 Walker Ave</u>	
PHYSICIAN'S NAME (Type) <u>GRACE G. JONES, M.D.</u>		DATE SIGNED <u>4/28/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 29, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		24a. REC'D BY REGISTRAR <u>DATE APR 30 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF REGISTRAR</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF WITNESSES</p>		<p>19. SIGNATURE OF PHYSICIAN</p>		<p>20. SIGNATURE OF CORONER</p>	
<p>21. SIGNATURE OF REGISTRAR</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF WITNESSES</p>		<p>24. SIGNATURE OF PHYSICIAN</p>	
<p>25. SIGNATURE OF CORONER</p>		<p>26. SIGNATURE OF REGISTRAR</p>		<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF WITNESSES</p>	
<p>29. SIGNATURE OF PHYSICIAN</p>		<p>30. SIGNATURE OF CORONER</p>		<p>31. SIGNATURE OF REGISTRAR</p>		<p>32. SIGNATURE OF DECEASED</p>	
<p>33. SIGNATURE OF WITNESSES</p>		<p>34. SIGNATURE OF PHYSICIAN</p>		<p>35. SIGNATURE OF CORONER</p>		<p>36. SIGNATURE OF REGISTRAR</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF WITNESSES</p>		<p>39. SIGNATURE OF PHYSICIAN</p>		<p>40. SIGNATURE OF CORONER</p>	
<p>41. SIGNATURE OF REGISTRAR</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF WITNESSES</p>		<p>44. SIGNATURE OF PHYSICIAN</p>	
<p>45. SIGNATURE OF CORONER</p>		<p>46. SIGNATURE OF REGISTRAR</p>		<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF WITNESSES</p>	
<p>49. SIGNATURE OF PHYSICIAN</p>		<p>50. SIGNATURE OF CORONER</p>		<p>51. SIGNATURE OF REGISTRAR</p>		<p>52. SIGNATURE OF DECEASED</p>	
<p>53. SIGNATURE OF WITNESSES</p>		<p>54. SIGNATURE OF PHYSICIAN</p>		<p>55. SIGNATURE OF CORONER</p>		<p>56. SIGNATURE OF REGISTRAR</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF WITNESSES</p>		<p>59. SIGNATURE OF PHYSICIAN</p>		<p>60. SIGNATURE OF CORONER</p>	
<p>61. SIGNATURE OF REGISTRAR</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF WITNESSES</p>		<p>64. SIGNATURE OF PHYSICIAN</p>	
<p>65. SIGNATURE OF CORONER</p>		<p>66. SIGNATURE OF REGISTRAR</p>		<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF WITNESSES</p>	
<p>69. SIGNATURE OF PHYSICIAN</p>		<p>70. SIGNATURE OF CORONER</p>		<p>71. SIGNATURE OF REGISTRAR</p>		<p>72. SIGNATURE OF DECEASED</p>	
<p>73. SIGNATURE OF WITNESSES</p>		<p>74. SIGNATURE OF PHYSICIAN</p>		<p>75. SIGNATURE OF CORONER</p>		<p>76. SIGNATURE OF REGISTRAR</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF WITNESSES</p>		<p>79. SIGNATURE OF PHYSICIAN</p>		<p>80. SIGNATURE OF CORONER</p>	
<p>81. SIGNATURE OF REGISTRAR</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF WITNESSES</p>		<p>84. SIGNATURE OF PHYSICIAN</p>	
<p>85. SIGNATURE OF CORONER</p>		<p>86. SIGNATURE OF REGISTRAR</p>		<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF WITNESSES</p>	
<p>89. SIGNATURE OF PHYSICIAN</p>		<p>90. SIGNATURE OF CORONER</p>		<p>91. SIGNATURE OF REGISTRAR</p>		<p>92. SIGNATURE OF DECEASED</p>	
<p>93. SIGNATURE OF WITNESSES</p>		<p>94. SIGNATURE OF PHYSICIAN</p>		<p>95. SIGNATURE OF CORONER</p>		<p>96. SIGNATURE OF REGISTRAR</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF WITNESSES</p>		<p>99. SIGNATURE OF PHYSICIAN</p>		<p>100. SIGNATURE OF CORONER</p>	

BUREAU V. 5

APR 30 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4303

CERTIFICATE OF DEATH

Reg. Dist. No.

04281

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Rest			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN 1437.2			
f. STREET ADDRESS COLLEGE HEIGHTS AVENUE				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN G KLEIN				4. DATE OF DEATH Month Day Year APRIL 1 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 4, 1887	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY PLUMBING COMPANY	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME NICHOLAS KLEIN			
14. MOTHER'S MAIDEN NAME MAGDALEN REESE				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-1			
16. SOCIAL SECURITY NO. 218-24-2648		17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA AND CONGESTION DUE TO HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypoplastic kidney, right							INTERVAL BETWEEN ONSET AND DEATH 30 MIN. UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 27, 1958 , to APRIL 1, 1958 , that I have the deceased alive and that death occurred at 1:40 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH FORT HOWARD MARYLAND DATE SIGNED 4-2-58 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH FORT HOWARD MARYLAND PHYSICIAN'S NAME (Type) CHIEN WEI LAN, MD. VAH Fort Howard Maryland 4-2-58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/58		22c. NAME OF CEMETERY OR CREMATORY CHESTER CEMETERY		22d. LOCATION (City, town, or county) (State) CHESTERTOWN MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIS WELLS				24a. REC'D BY REGISTRAR DATE APR 7 '58		24b. REGISTRAR'S SIGNATURE Al. Lewis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 1-1-10

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1873		5. PLACE OF BIRTH Maryland		6. OCCUPATION Farmer		7. MARITAL STATUS Married		8. COLOR White	
9. DECEASED AT Home		10. PLACE OF DEATH Home		11. DATE OF DEATH April 7, 1938		12. TIME OF DEATH 10:00 AM		13. CAUSE OF DEATH Heart Disease		14. DISEASE OR INJURY Coronary Artery Disease		15. PREVIOUS ILLNESS None		16. MEDICAL ATTENDANCE None	
17. SIGNATURE OF DECEASED James H. Harris		18. SIGNATURE OF WITNESS John D. Smith		19. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		20. SIGNATURE OF CLERK J. H. Harris		21. SIGNATURE OF REGISTRAR J. H. Harris		22. SIGNATURE OF JURY None		23. SIGNATURE OF JUDGE None		24. SIGNATURE OF SHERIFF None	
25. SIGNATURE OF DECEASED James H. Harris		26. SIGNATURE OF WITNESS John D. Smith		27. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		28. SIGNATURE OF CLERK J. H. Harris		29. SIGNATURE OF REGISTRAR J. H. Harris		30. SIGNATURE OF JURY None		31. SIGNATURE OF JUDGE None		32. SIGNATURE OF SHERIFF None	

BUREAU V. S.

APR 7 1938

RECEIVED

4304 CERTIFICATE OF DEATH

04282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8715 Liberty Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Adam Kloth		4. DATE OF DEATH Month April Day 14 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	8. DATE OF BIRTH May 15, 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Randallstown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Harmon Kloth		14. MOTHER'S MAIDEN NAME Barbara Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. James A. Kloth		Address Randallstown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) PULMONARY EDEMA - KIDNEY FAILURE - ASCITES (c) CORONARY OCCLUSION - FOLLOWING INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 1 year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSION - MOD - SEVERE -			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN - 19 , 19 58 , to APRIL 14 , 19 58 , that I last saw the deceased alive on APRIL 14 , 19 58 , and that death occurred at 10 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Wheeler		ADDRESS (Street, city or town, state) Randallstown - Md	
PHYSICIAN'S NAME (Type) THOMAS E. WHEELER		DATE SIGNED 4/15/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-17, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LOUISE BYERS		ADDRESS 8728 Liberty Road, Randallstown	
24a. REC'D BY REGISTRAR APR 16 '58		24b. REGISTRAR'S SIGNATURE W. H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 17 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4305 CERTIFICATE OF DEATH

Reg. Dist. No. 04283

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3 Mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle E. Last Kunkel				4. DATE OF DEATH Month April Day 21 Year 19 58.			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1873	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commission Merchant				10b. KIND OF BUSINESS OR INDUSTRY Live Stock		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Charles H. Kunkel				14. MOTHER'S MAIDEN NAME Harriet S. Redsecker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Eva G. Kunkel Address 1606 Rolling Road (27)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive A.S. CVD 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Coronary Occlusion DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jun 5, 1955 , to April 21, 1958 , that I last saw the deceased alive on April 19, 1958 , and that death occurred at 2:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED 4/24/58							
ACTUAL SIGNATURE John C. Healy M.D.				PHYSICIAN'S NAME (Type) John C. Healy MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-1958		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Strong ADDRESS 3207 W. North Ave				24a. REC'D BY REGISTRAR DATE APR 24 58		24b. REGISTRAR'S SIGNATURE W. J. ...	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

4306

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deer Park, Garrett Co.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 936 Imperial Court		d. STREET ADDRESS R. D. #2 936 Imperial Court	
3. NAME OF DECEASED (Type or print) First ELVIN Middle LANDIS Last LANDIS		4. DATE OF DEATH Month April Day 14 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1885
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) Railroad Fireman		10b. KIND OF BUSINESS OR INDUSTRY Railroad B & O	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN LANDIS		14. MOTHER'S MAIDEN NAME POLLY ANN SHIRK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---	
17. INFORMANT SAMUEL WEBER		Address Balt. 27 936 Imperial Court	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MARCH 4, 1958 , to APRIL 14, 1958 , that I last saw the deceased alive on APRIL 14, 1958 , and that death occurred at 7:15 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Arthur Rosberg M.D.		ADDRESS (Street, city or town, state) 2436 WASHINGTON BLVD BALTIMORE 30, MARYLAND	
PHYSICIAN'S NAME (Type) CARLTON ROSSBERG MD		DATE SIGNED 4/14/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/17/1958	22c. NAME OF CEMETERY OR CREMATORY King Cemetery	22d. LOCATION (City, town, or county) (State) MARYLAND GARRETT COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Leighton ADDRESS OAKLAND, MARYLAND		24a. REC'D BY REGISTRAR W. J. Leach 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

26

BUREAU V. S.

APR 17 1958

RECEIVED

04285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>			c. LENGTH OF STAY IN lb <u>6 mo.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6930 SOLLERS POINT ROAD</u>						d. STREET ADDRESS <u>1 6930 SOLLERS POINT ROAD</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERBERT CLINTON LANE</u>						4. DATE OF DEATH Month Day Year <u>APRIL 24 1958</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 28 1888</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LOCOMOTIVE FIREMAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>			11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>FRANK LANE, SR.</u>						14. MOTHER'S MAIDEN NAME <u>SARA HELLER</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. <u>705-12-1838</u>		17. INFORMANT Address <u>SARA LANE - SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-2 1955</u> , to <u>4-24 1958</u> , that I last saw the deceased alive on <u>4-24 1958</u> , and that death occurred at <u>4 PM</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2 Kinship Blvd 22 BALTIMORE MD.</u> DATE SIGNED <u>4-26-58</u> ACTUAL SIGNATURE <u>JACK COLLINS</u> M.D. PHYSICIAN'S NAME (Type) <u>JACK COLLINS, M.D. DUNDALK, MD.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>4/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEMETERY</u>			22d. LOCATION (City, town, or county) (State) <u>BALTIMORE CO. MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Povey, Dundalk, Md.</u> ADDRESS <u>Dundalk, Md.</u>						24a. REC'D BY REGISTRAR DATE <u>APR 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

VS A15 (4)
15M 9/55

VS A15 (4)
15M 9/55

BUREAU V. S.

APR 22 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04286

Items 8 & 9, Film G-228 4/21/58.cac.

4377
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall - 19 Harrison Ave.				d. STREET ADDRESS formerly of 623 W. Balto. St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Charles F. Lang				4. DATE OF DEATH Month April Day 14 Year 1958			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1873	
9. AGE (In years last birthday) yrs. 84		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist (rtd)		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Frederick Lang				14. MOTHER'S MAIDEN NAME Anna (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Edwin Ottenheimer - 111 N. Charles St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive failure DUE TO (c) Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Oct 1, 1954 , to Apr 14, 1958 , that I last saw the deceased alive on Apr 14, 1958 , and that death occurred at Md. from the causes and on the date stated above.							
ACTUAL SIGNATURE Harvey L. Fuller M.D.				ADDRESS (Street, city or town, state) Ridge Rd Baltimore 6 Md.			
PHYSICIAN'S NAME (Type) HARVEY L. FULLER				DATE SIGNED Apr 15 '58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/58		22c. NAME OF CEMETERY OR CREMATORY Balto. Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons. Balto				24a. REC'D BY REGISTRAR DATE APR 15 '58		24b. REGISTRAR'S SIGNATURE W. J. Tiekner	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

BUREAU V. 8

APR 16 1958

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7, Film G-228 4/23/58, cec.

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>3607 E. Joppa Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Leroy Elmer Lang.</u>		4. DATE OF DEATH <u>Apr. 2 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-29-05</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR: Months <u>2</u> Days <u>2</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Repair</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto Gas & Elec Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>215-07-6536</u>	
17. INFORMANT <u>Son.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr.</u> <u>2 + yrs.</u> <u>2.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u>		DATE SIGNED <u>4/2/58</u>	
EXAMINER'S NAME (Type) <u>FRANK T. KASIK, JR.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fork Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. Chomowicz Jr</u>		ADDRESS <u>3615-17-19 Chestnut Ave</u>	
24a. REC'D BY REGISTRAR <u>APR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 7 1938

BUREAU V. 1

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11

4309

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7623 Philadelphia Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth L. Langenfelder First Middle Last				4. DATE OF DEATH April 11 1958 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2, 1881	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME August G. Bartenfelder				14. MOTHER'S MAIDEN NAME Catherine Link			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT George Langenfelder Address 7623 Philadelphia Rd.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Cerebral apoplexy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease 5 yrs (c) 1 WK. INTERVAL BETWEEN ONSET AND DEATH 5 yrs							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1958 to April 10, 1958 , that I last saw the deceased alive on April 10, 1958 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE M Bannigundum M.D.				ADDRESS (Street, city or town, state) Baltimore Md		DATE SIGNED 4/11/58	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF April 14, 1958		22c. NAME OF CEMETERY OR CREMATORY Zion Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Stemmer's Run, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, Baltimore, Md.				24a. REC'D BY REGISTRAR DATE APR 17 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1908

10

BUREAU V. S.

APR 17 1908

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4310 CERTIFICATE OF DEATH

04289

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Balto., 4				c. LENGTH OF STAY IN 1b 3 1/2 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice				d. STREET ADDRESS 29 S. Pulaski			
3. NAME OF DECEASED (Type or print) First Middle Last Annie Marie Law				4. DATE OF DEATH Month Day Year April 20 19 58			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1871	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Ireland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Richard Law				14. MOTHER'S MAIDEN NAME Mary Daly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Admission record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 522X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH Sudden 2 Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 17, 1958 , to April 20, 1958 , that I last saw the deceased alive on April 19, 1958 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				ADDRESS (Street, city or town, state) 7501 York Rd 4120/58			
DATE SIGNED 4/20/58							
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.				Towson #4 md			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4-23-58		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Balto Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard G. Ruck, Inc.				ADDRESS 5305 Hayfield Rd		24a. REC'D BY REGISTRAR DATE APR 22 '58	
24b. REGISTRAR'S SIGNATURE W. J. Leach							

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John Doe		35		Male		White	
Date of Death		Place of Death		Cause of Death		Manner of Death	
April 10, 1933		Home		Heart Disease		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

Received of J. R. [illegible] 2302 - [illegible]
 New-Cottel [illegible]

RECEIVED
 APR 22 1933
 BUREAU V. S.

4311 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>19 Hrs. 50 M.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE W. LEACH</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 2, 1892</u>
9. AGE (In years last birthday) yrs. <u>66</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William J. Leach</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth E. England</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>218-10-4749</u>	
17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>18 HOURS</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OBESITY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>VA</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>AM</u>		20f. (City or town) (County) (State) <u>AM</u>	
21. I certify that I attended the deceased from <u>April 2, 11:00 P.M. 58</u> to <u>April 3, 6:50 P.M. 58</u> and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>I. Freeman</u>		M.D. <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>4/3/58</u>	
PHYSICIAN'S NAME (Type) <u>IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-7-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Cook, Inc., St. Paul & Preston Sts., Balto., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

APR 7 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #2, Film G228 - 4/23/58 - mb

04291

4312

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 7 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth Leary		4. DATE OF DEATH Month April Day 15 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1867
9. AGE (In years last birthday) yrs. 91		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Leary		14. MOTHER'S MAIDEN NAME Elizabeth Curran	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac failure DUE TO (c) Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 15, 19 58 , to April 18, 19 58 , that I last saw the deceased alive on April 18, 19 58 , and that death occurred at 5:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 4-18-58			
ACTUAL SIGNATURE Edmee Gens Reeves M.D.		PHYSICIAN'S NAME (Type) Edmee Gens Reeves	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 21, 19 58	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Catonsville 28, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Path Inc. 1735 Maryland Ave.		24a. REC'D BY REGISTRAR DATE APR 21 '58	
24b. REGISTRAR'S SIGNATURE Edmundson Ave Balto Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE

DATE OF DEATH

PLACE OF DEATH

EDUCATION

RELIGION

CAUSE OF DEATH

IMMEDIATE CAUSE

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

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TIME OF DEATH

PLACE OF DEATH

BUREAU V. B.

APR 21 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04292

4313 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY 3001-4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2825 Erdman Avenue, Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2825 Erdman Ave.	
3. NAME OF DECEASED (Type or print) ROBERT		4. DATE OF DEATH Month April Day 8 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 24, 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Automobile	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Link		14. MOTHER'S MAIDEN NAME Annie Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216-05-5578	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER WITH ASCITES 581.0 DUE TO MALNUTRITION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pneumonitis, left upper lobe		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 10 , 19 58 , to April 8 , 19 58 , and that death occurred at 5:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Chien Wei Lan		ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.		DATE SIGNED 4/9/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.		ADDRESS Baltimore, Maryland	
24a. REC'D BY REGISTRAR DATE APR 10 '58		24b. REGISTRAR'S SIGNATURE Alfred	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE, COUNTY AND STATE OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF BURIAL

NAME OF BURIAL PLACE

NAME OF MINISTER

NAME OF FUNERAL HOME

NAME OF CARRIER

NAME OF COFFIN

NAME OF CASK

NAME OF CASK

NAME OF CASK

NAME OF CASK

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BURKAV V. S.

APR 11 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04293

4314 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>6 yrs. 1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3Y01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sheppard & Enoch Pratt Hospital</u>				d. STREET ADDRESS <u>1306 Argonne Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annette</u> Middle <u>Shorey</u> Last <u>Llewelyn</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 8, 1878</u>		9. AGE (In years lost birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Covington, Ky.</u>	
13. FATHER'S NAME <u>DeWitt Shorey</u>				14. MOTHER'S MAIDEN NAME <u>Hanna Orr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260X</u> (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes; Chronic Brain Syndrome due to Arteriosclerosis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Towson</u>				20g. (County) <u>Towson</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>April 23, 1958</u> to <u>April 24, 1958</u> , that I last saw the deceased alive on <u>April 24, 1958</u> , and that death occurred at <u>2:10 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sheppard Pratt Hosp</u> DATE SIGNED <u>4/24/58</u> ACTUAL SIGNATURE <u>W.W. Elgin</u> M.D. PHYSICIAN'S NAME (Type) <u>W.W. Elgin</u> <u>Towson - 4 Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dornd Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikeville Ma</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. Jenkins</u>				ADDRESS <u>Ans Co 4905 York Rd</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. W. Elgin</u>							

BUREAU V. S.

APR 6 1953

RECEIVED

4315 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Balto. Co</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonoville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonoville 52</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>127 Newburg Ave</i>				d. STREET ADDRESS <i>127 Newburg Ave</i>			
3. NAME OF DECEASED (Type or print) <i>Bertha E. Lockard</i>				4. DATE OF DEATH <i>April 16 1958</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/26/1872</i>	9. AGE (In years last birthday) <i>85</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Henry W. Butschky</i>				14. MOTHER'S MAIDEN NAME <i>Burgan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>Matilda Witters</i>			
17. INFORMANT <i>Matilda Witters</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Hypostatic Pneumonia</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumothorax</i> DUE TO (c) <i>Cardio Vascular Disease & Hypertension</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>3 years</i> <i>10 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>6/1/32</i> , 19 <i>58</i> , to <i>4/16</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>4/16</i> , 19 <i>58</i> , and that death occurred at <i>5:50</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Eliot W. Johnson</i>				ADDRESS (Street, city or town, state) <i>3832 Judith Ave</i>			
DATE SIGNED <i>4/18/58</i>							
PHYSICIAN'S NAME (Type) <i>ELIOT W. JOHNSON M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>4/19/58</i>		<i>London Park</i>		<i>Balto. md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Macraeth + Son</i>				ADDRESS <i>28</i>		24a. REC'D BY REGISTRAR DATE <i>APR 22 '58</i>	
						24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X 31

APR 22 1958

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO-		4316		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO-21-		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex (21)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 333 E Riverside Ave				d. STREET ADDRESS 333 E Riverside Ave	
3. NAME OF DECEASED (Type or print) William First Daniel Middle Love Last		4. DATE OF DEATH April Month 10 Day 19 Year 58		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1952	9. AGE (in years last birthday) 5 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Christhper C. Love			14. MOTHER'S MAIDEN NAME Olive Bickel		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Christhper Love Address Same	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNIN 850.X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from Row Boat in Back River.			
20c. TIME OF INJURY Month, Day, Year 11 a. m. 4/10/58 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Back River	
				20f. (City or town) (County) (State) BALTO-21 BALTO-MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/10/58	
EXAMINER'S NAME (Type) M. B. Davis M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/12/58	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) BALTO. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James J. Brudzinski		ADDRESS 1407 Eastern Ave.		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Bar 1-10-

Bar 1-10-

333 E Riverside Ave

William Davis born April 10 1878

Drowning

For from ground in back yard. 4/10/28

BUREAU V. E.

APR 14 1928

RECEIVED

W.B. Davis M.D.

4207 CERTIFICATE OF DEATH

04296

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANSDOWN				c. LENGTH OF STAY IN 1b 47 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3161 SHILOH COURT				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) VICTOR First JOSEPH Middle MANKEVITZ Last				4. DATE OF DEATH APRIL 30, 1958 Month Day Year			
5. SEX M.		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 12, 1916 yrs.	
9. AGE (In years lost birthday) 41 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY TAILOR		11. BIRTHPLACE (State or foreign country) LITHUANIA	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-01-4473			
17. INFORMANT MRS WILLIAM F. JOHNSON Address 3161 SHILOH COURT, LANSDOWN 27, MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the Liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 27, 1958 , to April 30, 1958 , that I lost saw the deceased alive on April 29, 1958 , and that death occurred at 3:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 410 N. Helton St. Balto Md. DATE SIGNED 5/1/58							
ACTUAL SIGNATURE Morris W. Steinberg M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 3/58		22c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN		22d. LOCATION (City, town, or county) (State) GLENBURNIE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WITZKE FUNERAL DIRECTORS ADDRESS 410 EDMONDSON AVE.				24a. REC'D BY REGISTRAR MAY 5 '58 DATE		24b. REGISTRAR'S SIGNATURE W. W. W.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4317

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN lb 302 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
f. STREET ADDRESS 1533 Light Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NICOLO Middle NONE Last MARCELLINO				4. DATE OF DEATH Month April Day 13 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 2, 1893	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Repairer				10b. KIND OF BUSINESS OR INDUSTRY Shoe Repair Shop			
13. FATHER'S NAME Salvadore Marcellino				14. MOTHER'S MAIDEN NAME Carmella Russo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO.			
17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA RIGHT LUNG WITH METASTASIS 162.1 DUE TO TO LEFT LUNG. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MEDIASTINAL AND CERVICAL LYMPH NODES AND CERVICAL DUE TO VERTEBRAE (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 15, 1957 to April 13, 1958 and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Chien Wei-Lan M.D.							
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D. VAH, Fort Howard, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/15/58 22c. NAME OF CEMETERY OR CREMATORY Baltimore National 22d. LOCATION (City, town, or county) (State) Baltimore, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, INC ADDRESS 6009 Hayford Rd. 24a. REC'D BY REGISTRAR APR 21 '58 24b. REGISTRAR'S SIGNATURE W. L. ...							
25. Wm. Cook-Blight Funeral Home.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 22 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4197

CERTIFICATE OF DEATH

04298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Edgemere, Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3012 Salisbury Ave.		d. STREET ADDRESS 3012 Salisbury Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle A. Last Martin Sr.		4. DATE OF DEATH Month 4 Day 22 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 4 Days 22 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Martin		14. MOTHER'S MAIDEN NAME Sarah E.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 216-10-2791	
17. INFORMANT Mr. Edwin G. Martin		Address 3012 Salisbury Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease DUE TO (c) ± 10 years		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1958 , to 4-22, 1958 , that I last saw the deceased alive on 4-22, 1958 , and that death occurred at 9 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. G. Windsor M.D. 520 D St. SP19		DATE SIGNED 4-28	
PHYSICIAN'S NAME (Type) ROGER G WINDSOR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-26-1958	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Blvd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR app 29 '58		24b. REGISTRAR'S SIGNATURE Overman	

BUREAU V.

APR 29 1958

WASHINGTON
MAY 15 1964

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RECEIVED
APR 29 1958
BUREAU V. S.

APR 29 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4318

CERTIFICATE OF DEATH

04299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12 Washington Avenue		d. STREET ADDRESS 12 Washington Avenue	
3. NAME OF DECEASED (Type or print) First EMMA Middle LONG Last MAYER		4. DATE OF DEATH Month April Day 17 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1884
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 17 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adolphus M LONG		14. MOTHER'S MAIDEN NAME Annie Cathcart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 443X DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 28th , 1958, to April 17th , 1958, that I last saw the deceased alive on April 16th , 1958, and that death occurred at 6:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1927 York Rd, Timonium 4/18/58 DATE SIGNED ACTUAL SIGNATURE M. K. Quinn M.D. PHYSICIAN'S NAME (Type) M. K. QUINN M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 19, 1958	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons,		ADDRESS Towson, Md.	
24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE Al L. Smith	

RECEIVED

4319

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 1718 Yokoma Road			
3. NAME OF DECEASED (Type or print) First JOHN Middle E. Last McCOY				4. DATE OF DEATH Month April Day 15 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1922		9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George McCoy				14. MOTHER'S MAIDEN NAME Lillian Frey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 217-24-0558		17. INFORMANT Address Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA AND UREMIC PERICARDITIS 592x DUE TO GLOMERULONEPHRITIS, CHRONIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 10 Days 13 Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 9, 1958 to April 15, 1958 and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Chien Wei Lan M.D. 4/15/58 PHYSICIAN'S NAME (Type) CH IEN WEI LAN, M. D. VAH, Fort Howard, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-18-58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blythe Inc. 6009 Harbor Rd				24a. REC'D BY REGISTRAR DATE APR 21 '58		24b. REGISTRAR'S SIGNATURE Wm Cook-Blythe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

APR 22 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04301

4320

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5yr9mths14dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First May Middle Mary Last Mc Donough		4. DATE OF DEATH Month April Day 1 Year 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1870
9. AGE (In years last birthday) yrs. 87		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander McDonough		14. MOTHER'S MAIDEN NAME Ann McDonough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1958 , to April 1, 1958 , that I last saw the deceased alive on April 1, 1958 , and that death occurred at 4:00p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		DATE SIGNED 4-1-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 10, 1958	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		ADDRESS 1217 St. Paul Street	
24a. REC'D BY REGISTRAR APR 9 '58		24b. REGISTRAR'S SIGNATURE W. J. Leach	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

APR 9 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04302

4321 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN TB 7 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES P MCGREGOR		4. DATE OF DEATH Month Day Year APRIL 18 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 5, 1900
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CITY SANITATION	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM H. MCGREGOR		14. MOTHER'S MAIDEN NAME MARY CATHERINE MCCORT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO.	
17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE, INTRACEREBRAL 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) UNKNOWN CAUSE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 11, 1958 , to APRIL 18, 1958 , and that death occurred at 10:15 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH FORT HOWARD Maryland 4-19-58 ACTUAL SIGNATURE George Vash M.D. PHYSICIAN'S NAME (Type) GEORGE VASH M.D. VAH FORT HOWARD MARYLAND 4-19-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-22-58	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE M. Cook-Blight, Inc., 6009 Harford Rd Baltimore Md		24a. REC'D BY REGISTRAR APR 21 '58	
24b. REGISTRAR'S SIGNATURE Alfred...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERGYMAN		19. SIGNATURE OF BURIAL OFFICIAL		20. SIGNATURE OF FUNERAL HOME	
21. SIGNATURE OF CORONER		22. SIGNATURE OF JURY		23. SIGNATURE OF JUDGE		24. SIGNATURE OF DISTRICT ATTORNEY		25. SIGNATURE OF COUNTY CLERK	
26. SIGNATURE OF STATE DEPARTMENT OF HEALTH		27. SIGNATURE OF BALTIMORE CITY DEPARTMENT OF HEALTH		28. SIGNATURE OF ANN ARBOR CITY DEPARTMENT OF HEALTH		29. SIGNATURE OF BETHESDA CITY DEPARTMENT OF HEALTH		30. SIGNATURE OF ROCKVILLE CITY DEPARTMENT OF HEALTH	
31. SIGNATURE OF GAITHERSBURG CITY DEPARTMENT OF HEALTH		32. SIGNATURE OF GREENBELT CITY DEPARTMENT OF HEALTH		33. SIGNATURE OF HAGERSTOWN CITY DEPARTMENT OF HEALTH		34. SIGNATURE OF LAUREL CITY DEPARTMENT OF HEALTH		35. SIGNATURE OF Pikesville CITY DEPARTMENT OF HEALTH	
36. SIGNATURE OF PRAIRIE CITY DEPARTMENT OF HEALTH		37. SIGNATURE OF RIVERDALE CITY DEPARTMENT OF HEALTH		38. SIGNATURE OF SEABOARD CITY DEPARTMENT OF HEALTH		39. SIGNATURE OF SODDY CITY DEPARTMENT OF HEALTH		40. SIGNATURE OF TOWSON CITY DEPARTMENT OF HEALTH	
41. SIGNATURE OF WILMINGTON CITY DEPARTMENT OF HEALTH		42. SIGNATURE OF YACHTSBOURNE CITY DEPARTMENT OF HEALTH		43. SIGNATURE OF BALTIMORE COUNTY DEPARTMENT OF HEALTH		44. SIGNATURE OF CARROLL COUNTY DEPARTMENT OF HEALTH		45. SIGNATURE OF CECIL COUNTY DEPARTMENT OF HEALTH	
46. SIGNATURE OF HARFORD COUNTY DEPARTMENT OF HEALTH		47. SIGNATURE OF HOWARD COUNTY DEPARTMENT OF HEALTH		48. SIGNATURE OF MONTGOMERY COUNTY DEPARTMENT OF HEALTH		49. SIGNATURE OF PRINCE GEORGES COUNTY DEPARTMENT OF HEALTH		50. SIGNATURE OF ST. MARYS COUNTY DEPARTMENT OF HEALTH	
51. SIGNATURE OF TALBOT COUNTY DEPARTMENT OF HEALTH		52. SIGNATURE OF WASHINGTON COUNTY DEPARTMENT OF HEALTH		53. SIGNATURE OF WICOMICO COUNTY DEPARTMENT OF HEALTH		54. SIGNATURE OF WYOMING COUNTY DEPARTMENT OF HEALTH		55. SIGNATURE OF ALLEGANY COUNTY DEPARTMENT OF HEALTH	
56. SIGNATURE OF ARMY COUNTY DEPARTMENT OF HEALTH		57. SIGNATURE OF BARBERSBURG CITY DEPARTMENT OF HEALTH		58. SIGNATURE OF BELLEVILLE CITY DEPARTMENT OF HEALTH		59. SIGNATURE OF BETHESDA CITY DEPARTMENT OF HEALTH		60. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH	
61. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		62. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		63. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		64. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		65. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH	
66. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		67. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		68. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		69. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		70. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH	
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76. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		77. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		78. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		79. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		80. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH	
81. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		82. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		83. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		84. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		85. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH	
86. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		87. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		88. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		89. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		90. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH	
91. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		92. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		93. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		94. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		95. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH	
96. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		97. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		98. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		99. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH		100. SIGNATURE OF BOWEN CITY DEPARTMENT OF HEALTH	

BUREAU V. & B.

APR 22 1953

RECEIVED

4322

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Florence Gertrude McMahon		4. DATE OF DEATH Month Day Year 4-9-58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-5-84
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Ontario, Canada		12. CITIZEN OF WHAT COUNTRY? Canada ✓	
13. FATHER'S NAME M John McIntyre		14. MOTHER'S MAIDEN NAME Jane Bowes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Margaret Brakefield		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensative Cardio Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pathological fracture Left femur, middle third			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 6 , 19 58 , to April 9 , 19 58 , that I last saw the deceased alive on April 9 , 19 58 , and that death occurred at 6:11 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6805 York Rd Baltimore 12 Md DATE SIGNED			
ACTUAL SIGNATURE Laurence C. Post M.D.			
PHYSICIAN'S NAME (Type) LAURENCE C. Post			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-11-58	
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill		22d. LOCATION (City, town, or county) (State) Towson 4, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Isaac Brooks		24a. REC'D BY REGISTRAR DATE APR 14 '58	
ADDRESS 622 York Rd., Towson 4, Md		24b. REGISTRAR'S SIGNATURE Arthur Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

APR 14 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4323. CERTIFICATE OF DEATH

04304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4306 Kenwood Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernst</u> Middle <u>K.</u> Last <u>Micklich</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1870</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick A. H. Micklich</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth E. M. Roschke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-12-6561A</u>	
17. INFORMANT Address <u>Mrs. Albert Dank 4501 Mary Ave. Balto. 6, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>many yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June, 1948</u> , to <u>April 18, 1958</u> , that I last saw the deceased alive on <u>April 17, 1958</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Max R. English</u> M.D.		ADDRESS (Street, city or town, state) <u>5713 Belair Rd Baltimore 6 Md.</u> DATE SIGNED <u>4-21-58</u>	
PHYSICIAN'S NAME (Type) <u>Max R. English M.D.</u>		<u>Baltimore 6 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 22, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Losach Funeral Home 7401 Belair Rd</u>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>APR 22 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 22 1959

BUREAU V. S.

4324

CERTIFICATE OF DEATH

04305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1704 Goodview Road</u>		d. STREET ADDRESS <u>1704 Goodview Road</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. Harry</u> First <u>Mills</u> Middle <u>Mills</u> Last		4. DATE OF DEATH <u>April 8th</u> 19 <u>58</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13, 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Mills</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>414-18-6994</u>	
17. INFORMANT <u>Mrs. Viola Mills</u> Address <u>1704 Goodview Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb., 1957</u> , to <u>April 8, 1958</u> , that I last saw the deceased alive on <u>April 7, 1958</u> , and that death occurred at <u>9:00</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. A. Grott</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4/8/58</u>	
PHYSICIAN'S NAME (Type) <u>H. A. Grott, M.D.</u>		<u>Balto., Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Disease		Occupation	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Report		Time of Report		Place of Report	

BUREAU Y. S.

APR 9 1938

RECEIVED

4325

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle (NMI) Last MITTEN		4. DATE OF DEATH Month APRIL Day 18 Year 19 58	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 9, 1889
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABELLER		10b. KIND OF BUSINESS OR INDUSTRY BOX FACTORY	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OSCAR MITTEN		14. MOTHER'S MAIDEN NAME JULIA (MAIDEN NAME UNKNOWN)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 218-03-8988	
17. INFORMANT CLIN REC VET ADM HOSP FORT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSION DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April 16, 19 58 , to April 18, 19 58 , that he was deceased on April 18, 19 58 , and that death occurred at 8:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Donald D Mark</i>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) DONALD D MARK		M.D. VAH FORT HOWARD MARYLAND 4-20-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF April 24, 58	
22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles B. Lewis</i> Charles B. Lewis 1639 N Broadway Baltimore Md		24a. REC'D BY REGISTRAR DATE APR 22 '58	
24b. REGISTRAR'S SIGNATURE <i>Alfred</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

APR 22 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4326

CERTIFICATE OF DEATH

Reg. Dist. No.

04307

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>18 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. STREET ADDRESS <u>1121 Tyler Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>C.</u> Last <u>MOATE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1907</u>
9. AGE (In years birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Clearfield, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James W. Moate</u>		14. MOTHER'S MAIDEN NAME <u>Stella Fiefield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>578-05-1786</u>	
17. INFORMANT <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PURULENT PERICARDITIS</u> <u>432 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MURAL THROMBI OF HEART WITH INFARCTS OF SPLEEN</u> (c) <u>AND KIDNEY</u> INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Operation- Embolectomy - terminal aorta- 4/1/58</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 21</u> , 19 <u>58</u> , to <u>April 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 19</u> , 19 <u>58</u> , and that death occurred at <u>6:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>VAH, Fort Howard, Maryland</u> <u>4/8/58</u> ACTUAL SIGNATURE <u>Chien Wei Ian</u> PHYSICIAN'S NAME (Type) <u>CHIEN WEI IAN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-11-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Taylor Funeral Home, Annapolis, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>APR 10 58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

CERTIFICATE OF DEATH

1933

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.



BUREAU V. 4

APR 10 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04308

4327

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Towson		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 1 Yr., 9 Mos.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Sheppard and Enoch Pratt Hospital			d. STREET ADDRESS 100 W. University Parkway		
3. NAME OF DECEASED (Type or print) First Henry Middle Ludwell Last Moore			4. DATE OF DEATH Month April Day 28 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1869		9. AGE (In years last birthday) 88 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if self-employed) Professor of Economics, Romance Languages & Sociology			10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME William Hanson Moore			14. MOTHER'S MAIDEN NAME Alice Burch		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of aortic aneurysm 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Termin 2 yr +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome: Cerebral arteriosclerosis					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 28, 1956 to April 28, 1958 , that I last saw the deceased alive on April 28, 1958 , and that death occurred at 11:40 A.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE W.W. Elgin		ADDRESS (Street, city or town, state) Sheppard Pratt Hosp. Towson - Md.		DATE SIGNED 4/28/58	
PHYSICIAN'S NAME (Type) W.W. Elgin					
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 4-29-58	22c. NAME OF CEMETERY OR CREMATORY GREENMOUNT		22d. LOCATION (City, town, or county) (State) BALTIMORE MD
23. FUNERAL DIRECTOR'S SIGNATURE H.W. JENKINS & SONS CO.			24a. REC'D BY REGISTRAR APR 30 '58		
ADDRESS 4905 YORK RD. BALTO, MD			24b. REGISTRAR'S SIGNATURE Alfred Burch		

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8 & 9, Film G228, 4/28/58 fcy
CERTIFICATE OF DEATH

Reg. Dist. No.

04309

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 E. Burke Avenue		d. STREET ADDRESS 3 E. Burke Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eugene Middle G. Last Morris		4. DATE OF DEATH Month April Day 14 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1896
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Mears, Druggist	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene M. Morris		14. MOTHER'S MAIDEN NAME Margaret Maloney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Eugene Robert Morris		Address 3 E. Burke Ave. Towson Md	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 12, 1958 , to April 14, 1958 , that I last saw the deceased alive on April 12, 1958 , and that death occurred at 5 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Rd DATE SIGNED 4/15/58	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell		Towson Md Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 17, 1958	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Mealy ADDRESS Box 805 N. Calvert St		24a. REC'D BY REGISTRAR APR 18 '58 DATE	
		24b. REGISTRAR'S SIGNATURE W. W. Mealy	

RECEIVED

BUREAU V. S.

APR 12 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4329

CERTIFICATE OF DEATH

Reg. Dist. No. 04310

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WOODLAWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WOODLAWN			
c. LENGTH OF STAY IN 1b 7.5 YRS				d. STREET ADDRESS BELMONT AVE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BELMONT AVE				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BERTHA Middle MAY Last MULLINEUX				4. DATE OF DEATH Month 4 Day 18 Year 1958			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 2, 1882	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 7 Days 18 Hours 19 Min.		IF UNDER 24 HRS. Months 7 Days 18 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOSEPH HENRICK				14. MOTHER'S MAIDEN NAME GRACE LOWREY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-38-7212			
17. INFORMANT Mrs Grace M. Zimmerman				Address Belmont Ave. Woodlawn, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE C.V. DISEASE DUE TO (c) DIABETES MELLITUS INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 10 YEARS 8 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) BALTIMORE				20g. (County) BALTIMORE		20h. (State) MARYLAND	
21. I certify that I attended the deceased from May 1957 to April 18, 1958 , that I last saw the deceased alive on 4/16, 1958 , and that death occurred at 5:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edwin L. Pierpont				DATE SIGNED 4/18/58			
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT				ADDRESS (Street, city or town, state) 8204 LIBERTY RD, BALTO. 2, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 21, 1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown, Balto. Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edna L. Lamoreau				24a. REC'D BY REGISTRAR APR 21 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 21 1958

RECEIVED

4330

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	c. LENGTH OF STAY IN 1b <u>2 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2110 Old Edmondson Ave</u>		d. STREET ADDRESS <u>2110 Old Edmondson Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine E. Newton</u>		4. DATE OF DEATH Month Day Year <u>4 2 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/18/1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crummer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lion Bros Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
13. FATHER'S NAME <u>William E. Joyce</u>		14. MOTHER'S MAIDEN NAME <u>Louisa C. Silverzahn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Thelma C. Airey</u>		Address <u>Old Edmondson Ave</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1956</u> to <u>April 1958</u> that I last saw the deceased alive on <u>Jan 1958</u> , and that death occurred at <u>400 P. M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1303 Frederick Rd Catonsville md 3 April 58</u>	
ACTUAL SIGNATURE <u>W. E. McGreth</u>		M.D. <u>W. E. McGreth</u>	
PHYSICIAN'S NAME (Type) <u>W. E. McGreth</u>		ADDRESS <u>Catonsville md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u>		ADDRESS <u>42 Hollins St.</u>	
24a. REC'D BY REGISTRAR <u>APR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
CERTIFICATE OF DEATH

BUREAU V. 3

APR 7 1958

RECEIVED

4331

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>			c. LENGTH OF STAY IN 1b <u>13 Days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3 Vol-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>2208 North Monroe Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>NATHANIEL P. NICHOLS</u>				4. DATE OF DEATH Month Day Year <u>April 9 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 12, 1914</u> 44 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>Petersburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry O. Nichols</u>				14. MOTHER'S MAIDEN NAME <u>Annie Powell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>219-01-5235</u>		17. INFORMANT Address <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOULAR NEPHROSCLEROSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 YEARS</u> <u>3 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHOPNEUMONIA, RIGHT LOWER LOBE</u> 491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>VA</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 27</u> , 19 <u>58</u> , to <u>April 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>58</u> , and that death occurred at <u>1:22 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>VAH, FORT HOWARD, MARYLAND</u> <u>4/10/58</u> ACTUAL SIGNATURE <u>Chien Wei-Lan</u> M.D. PHYSICIAN'S NAME (Type) <u>CHIEN WEI LAN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-14-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law Mortuary, 802-04 Madison Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Chien Wei-Lan</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.	
FATHER'S NAME		MOTHER'S NAME		MARRIED		SINGLE		WIDOWED		DIVORCED		MARRIED		SINGLE	
JAMES EARL RAY		JAMES EARL RAY		MARRIED		SINGLE		WIDOWED		DIVORCED		MARRIED		SINGLE	
OCCUPATION		EDUCATION		RELIGION		MANNER OF DEATH		CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
MEMBER OF ARMY		HIGH SCHOOL		METHODIST		SUICIDE		SUICIDE		SUICIDE		SUICIDE		SUICIDE	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
APR 4 1968		MEMPHIS, TENN.		APR 4 1968		MEMPHIS, TENN.		APR 4 1968		MEMPHIS, TENN.		APR 4 1968		MEMPHIS, TENN.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
APR 4 1968		MEMPHIS, TENN.		APR 4 1968		MEMPHIS, TENN.		APR 4 1968		MEMPHIS, TENN.		APR 4 1968		MEMPHIS, TENN.	

RECEIVED
APR 14 1968
BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4198

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Dundalk

c. LENGTH OF STAY IN 1b

6mo

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

53 Dundalk

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2084 Jasmine Rd

d. STREET ADDRESS

2084 Jasmine Rd

e. IS RESIDENCE
ON A FARM?YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

Ida

First

E

Middle

Nillert

Last

4. DATE
OF
DEATH

Month

Day

Year

April

21

1958

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

June 1 1873

9. AGE (In years
last birthday)

84 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John H Clark

14. MOTHER'S MAIDEN NAME

Elizabeth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Address

Dell Brown 803 Oak St. Winnetka Ill.

18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

9040

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Fractured left Hip -

INTERVAL BETWEEN
ONSET AND DEATH

5 wks -

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

1914 Unusual Bacter. Pneumonia

20a. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell in Bat Room -

20c. TIME OF INJURY

Hour 3:17 PM

Month/Day/Year 3/17/58 19

20d. INJURY OCCURRED

While ☒ Not while ☐
of work of work20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Home

20f. (City or town)

Dundalk Md

(County)

Baltimore

(State)

Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

M. B. Davis

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

4/2/58

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

April 24 1958

22c. NAME OF CEMETERY OR CREMATORY

Greenmount Cem

22d. LOCATION (City, town, or county)

Baltimore

(State)

Md

23. FUNERAL DIRECTOR'S SIGNATURE

J. Melville Jenkins 2713 Kirk Ave.

ADDRESS

24a. REC'D BY REGISTRAR

DATE APR 24 '58

24b. REGISTRAR'S SIGNATURE

W. J. Smith

FOR STATE
HEALTH DEPT.

1



BUREAU V. 2

APR 24 1953

RECEIVED

4332

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>55 Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armacost Nursing Home</i>		d. STREET ADDRESS <i>131 Regester Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Miss Elizabeth Noonan</i>		4. DATE OF DEATH <i>April 26th 19 58</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 27, 1880</i>
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jeremiah Noonan</i>		14. MOTHER'S MAIDEN NAME <i>Mary Hennessey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Mrs. Eileen Taylor, 131 Regester Avenue</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardio-</i> DUE TO (c) <i>Renal Vascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>72 hrs</i> <i>10 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 19 58</i> to <i>April 26 19 58</i> , that I last saw the deceased alive on <i>April 26 19 58</i> , and that death occurred at <i>4:30 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles F. O'Donnell M.D.</i>		ADDRESS (Street, city or town, state) <i>7501 York Rd</i>	
PHYSICIAN'S NAME (Type) <i>Charles F. O'Donnell M.D. Towson #4 Md</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/29/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>MAY 1 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4333 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>617 Wooddale</u>				d. STREET ADDRESS <u>617 Wooddale</u>			
3. NAME OF DECEASED (Type or print) First <u>MOLLIE</u> Middle <u>OBERSEIDER</u> Last <u></u>				4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/24/79</u>	9. AGE (In years last birthday) <u>78</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Johann Gechter</u>				14. MOTHER'S MAIDEN NAME <u>Bucher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs Emmett Zimmerman</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>47</u> , to <u>April</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 10</u> , 19 <u>58</u> , and that death occurred at <u>2:30A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1 Mallow Hill Ave., Baltimore 29, Md.</u> DATE SIGNED <u>4/12/58</u>							
ACTUAL SIGNATURE <u>Leo J. Gayer</u> M.D. <u>1 Mallow Hill Ave., Baltimore 29, Md.</u>				DATE SIGNED <u>4/12/58</u>			
PHYSICIAN'S NAME (Type) <u>Leo J. Gayer, M.D.</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grundy Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Macnab + son</u> ADDRESS <u>28</u>				24a. REC'D BY REGISTRAR DATE <u>APR 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>West</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

Reg. Dist. No. 04316

CERTIFICATE OF DEATH

Reg. Dist. No. 04316

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN lb 4mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 Vol. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5543 Link Ave.				d. STREET ADDRESS 4713 Dunkirk Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Ruth		Middle Catherine		Last O'Brennan	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 27, 1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH Month April	
Day 4		Year 1958					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William P. Bushman				14. MOTHER'S MAIDEN NAME Agnes Storm			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Mrs. Maude Myers 5543 Link Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x DUE TO Coriular flutter Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-vascular renal disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 10 , 19 57 , to Apr. 4 , 19 58 , that I last saw the deceased alive on Apr. 4 , 19 58 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 805 Frederick Ave 28 Md DATE SIGNED L. F. S.							
ACTUAL SIGNATURE George E. URBAN		PHYSICIAN'S NAME (Type) George E. URBAN					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-8-58		22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.		22d. LOCATION (City, town, or county) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville, Md.				ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR DATE APR 9 '58	
				24b. REGISTRAR'S SIGNATURE Al. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, and removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

APR 9 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4334

CERTIFICATE OF DEATH

04317

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Rural Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road				d. STREET ADDRESS Glenarm Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Sister Mary Albertus O'Hara				4. DATE OF DEATH Month April Day 12 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1888		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrence O'HARA				14. MOTHER'S MAIDEN NAME Anne McGovern			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Sister M. Peter Fourier		Address Notch Cliff, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 19 57 , to April 19 58 , that I last saw the deceased alive on April 8th 19 58 , and that death occurred at 6.12 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles F. O'Donnell M.D. 7501 York Road Towson 4, Md. 4/12-58							
ACTUAL SIGNATURE Charles F. O'Donnell							
PHYSICIAN'S NAME (Type) Charles F. O'Donnell							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-14-58		22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR TOWSON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Giller				24a. REC'D BY REGISTRAR DATE APR 15 '58		24b. REGISTRAR'S SIGNATURE Albert E. ...	

BUREAU V. S.

APR 15 1953

RECEIVED

4335 CERTIFICATE OF DEATH

04318

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 Osborne Ave.				d. STREET ADDRESS 3 Osborne Ave.			
3. NAME OF DECEASED (Type or print) First Hanly Middle Woodin Last Oswald				4. DATE OF DEATH Month April Day 23 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 31, 1893		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Agent		10b. KIND OF BUSINESS OR INDUSTRY Fuel Co.		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard W. Oswald				14. MOTHER'S MAIDEN NAME Elizabeth Hanly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W.W.L		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address W. Bruce Oswald 405 Forest Lane 28			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Degenerative C.V.D. DUE TO (c) Generalized Arterio Sclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 Day 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-22 , 19 58 , to 4-23 , 19 58 , that I last saw the deceased alive on 4-23 , 19 58 , and that death occurred at 6:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James Estowes M.D.				ADDRESS (Street, city or town, state) Catonsville DATE SIGNED 4-25			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-26-58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville, Md.				24a. REC'D BY REGISTRAR DATE APR 28 '58		24b. REGISTRAR'S SIGNATURE W. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4336

Reg. Dist. No. 04319

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8128 Loch Raven Blvd</u>			d. STREET ADDRESS <u>8128 Loch Raven Blvd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Mr. Leonard G. Otto, Sr</u>			4. DATE OF DEATH Month <u>April</u> Day <u>14th</u> Year <u>19 58</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 22, 1884</u>		9. AGE (In years last birthday) <u>73</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Optician</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Andrew Otto</u>			14. MOTHER'S MAIDEN NAME <u>Eva Dressell</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Mrs. Ella M. Otto, 8128 Loch Raven.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/14/58</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/17/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		(State)		24a. REC'D BY REGISTRAR <u>W. Search</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>		24b. REGISTRAR'S SIGNATURE	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4337 CERTIFICATE OF DEATH

04320

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home 5743 Edmondson Avenue		d. STREET ADDRESS Reisterstown Road	
3. NAME OF DECEASED (Type or print) BARNEY		4. DATE OF DEATH April 25 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1886
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Operator		10b. KIND OF BUSINESS OR INDUSTRY Street Railways	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Owings		14. MOTHER'S MAIDEN NAME Lydia Bowersox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-10-153	
17. INFORMANT Mr. Barney Owings-1740 Reisterstown Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal nephrosclerosis DUE TO Arteriosclerosis generalizid Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 446x (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of prostate.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 10 19 58 , to April 15 19 58 , that I last saw the deceased alive on April 15 19 58 , and that death occurred at 4:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Morton M. Krieger M.D.		ADDRESS (Street, city or town, state) 2108 Eutaw Place DATE SIGNED 3/26/58	
PHYSICIAN'S NAME (Type) MORTON M. KRIEGER		2108 Eutaw Place	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/28/58	22c. NAME OF CEMETERY OR CREMATORY Stone Chapel Cemetery	22d. LOCATION (City, town, or county) (State) Pikesville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Son ADDRESS Balto - 17. Md.		24a. REC'D BY REGISTRAR APR 28 1958 DATE	
24b. REGISTRAR'S SIGNATURE Wm. J. Lickner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4338

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <div>Baltimore</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <div>Maryland</div> <div>Balto.</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div>Catonsville</div>		c. LENGTH OF STAY IN 1b <div>1 mth3dys</div>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <div>SPRING GROVE STATE HOSPITAL</div>		d. STREET ADDRESS <div>Cockeysville, Maryland</div>	
3. NAME OF DECEASED (Type or print) <div>Mato</div>		4. DATE OF DEATH Month <div>April</div> <div>23</div> <div>19</div> <div>58</div>	
5. SEX <div>male</div>		6. COLOR OR RACE <div>white</div>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <div>unk.</div> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div>Feb. 24, 1880</div>	
9. AGE (In years last birthday) <div>78</div> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div>unknown</div>		10b. KIND OF BUSINESS OR INDUSTRY <div>Austria</div>	
11. BIRTHPLACE (State or foreign country) <div>Austria</div>		12. CITIZEN OF WHAT COUNTRY? <div>Austria</div>	
13. FATHER'S NAME <div>George</div>		14. MOTHER'S MAIDEN NAME <div>Mary</div>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <div>unknown</div>		16. SOCIAL SECURITY NO. <div>Unknown</div>	
17. INFORMANT <div>Records: SPRING GROVE STATE HOSPITAL</div>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div>Arteriosclerotic cardiovascular disease</div> <div>422.1</div> <div>DUE TO</div> <div>Generalized arteriosclerosis</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</div> <div>(b)</div> <div>DUE TO</div> <div>(c)</div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <div>19</div>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <div>March 5</div> , 19 <div>58</div> , to <div>April 23</div> , 19 <div>58</div> , that I last saw the deceased alive on <div>April 23</div> , 19 <div>58</div> , and that death occurred at <div>5:50p</div> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <div>Stella Wachler</div> M.D. <div>SPRING GROVE STATE HOSPITAL</div> <div>4-24-58</div> PHYSICIAN'S NAME (Type) <div>Stella Wachler, M. D.</div> <div>Catonsville 28, Maryland</div>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <div>Burial</div>		22b. DATE THEREOF <div>4/25/58</div>	
22c. NAME OF CEMETERY OR CREMATORY <div>Catholic</div>		22d. LOCATION (City, town, or county) <div>1360 Old Frederick</div>	
23. FUNERAL DIRECTOR'S SIGNATURE <div>John J. Lohay</div>		ADDRESS <div>1318 L...</div>	
24. REC'D BY REGISTRAR DATE <div>APR 25 '58</div>		24b. REGISTRAR'S SIGNATURE <div>...</div>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

BUREAU V. S.

APR 25 1953

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4339

CERTIFICATE OF DEATH

04322

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>1142 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>LEE</u> Last <u>PEDDICORD</u>				4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1893</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Albert B. Peddicord</u>				14. MOTHER'S MAIDEN NAME <u>Suzie L. Cook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>218-03-4725</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ESOPHAGEAL VARICES WITH BLEEDING HEMORRHAGIC</u> <u>581.0</u> DUE TO <u>DIATHESIS OF INTESTINAL TRACT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DUE TO CIRRHOSIS OF LIVER</u> (c) <u>HEMOCHROMATOSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>1 WEEK</u> <u>3 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Peptic ulcer, duodenal</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <u>February 26, 1955</u> to <u>April 13, 1958</u> that I last saw the deceased alive on <u>XXXXXX</u> and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>VA HOSPITAL, FORT HOWARD, MARYLAND</u> <u>4/14/58</u> ACTUAL SIGNATURE <u>Chien Wei Lan</u> PHYSICIAN'S NAME (Type) <u>CHIEN WEI LAN, M.D.</u> <u>VAH, FORT HOWARD, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 21 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Cook-Blight</u>	

RECEIVED

4340

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 124 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1930 McCULLOH STREET	
3. NAME OF DECEASED (Type or print) First GERSON Middle L Last PERRY		4. DATE OF DEATH Month APRIL Day 4 Year 1958	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH APRIL 13, 1898
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO MECHANIC	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE PERRY		14. MOTHER'S MAIDEN NAME ELLA JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-1		16. SOCIAL SECURITY NO. 216-05-8517	
17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ENCEPHALOMALACIA LEFT CEREBRAL CORTEX DUE TO 904.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SUBDURAL HEMORRHAGE DUE TO (c) FRACTURE OF THE SKULL		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PORTAL CIRRHOSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown. Found on street by police	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12 p. m. 1 1958	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Baltimore City Md.
21. I certify that I attended the deceased from DECEMBER 1, 1957 , to APRIL 4, 1958 and that death occurred at 9:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Donald D Mark</i>		ADDRESS (Street, city or town, state) VAH Fort Howard Maryland	
PHYSICIAN'S NAME (Type) DONALD D MARK		DATE SIGNED 4-6-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Apr. 9, 1958	22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles Rice</i> ADDRESS Charles Rice 661 W Barre St Balto Md		24a. REC'D BY REGISTRAR DATE APR 11 '58	
		24b. REGISTRAR'S SIGNATURE <i>Alfred</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

WILLIAM BOND

BUREAU V. S.

APR 14 1933

RECEIVED

4341

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

4342

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 4 mos. 15 days x Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				/d. STREET ADDRESS 3622 Milford Mill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Blanche Middle M. Last Phillips				4. DATE OF DEATH Month April Day 5 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-6 year unknown 1863	
				9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Washburn				14. MOTHER'S MAIDEN NAME Martha Keith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mrs. Zealous Hummer Address 3622 Millford Mill Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cellulitis right arm and chest							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7 , 19 58 , to April 5 , 19 58 , that I last saw the deceased alive on April 5 , 19 58 , and that death occurred at 7:00p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL			
DATE SIGNED 4-6-58							
PHYSICIAN'S NAME (Type) STELLA WACHSLER				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		4/8, 1958		St. Charles Cemetery		Randallstown Md	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				ADDRESS Funeral Home, Randallstown, Md.		24a. REC'D BY REGISTRAR DATE APR 10 '58	
				24b. REGISTRAR'S SIGNATURE DeW...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

APR 10 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4343 CERTIFICATE OF DEATH

Reg. Dist. No.

04326

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Fred.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen 10X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS Victor Cullen State Hosp.			
3. NAME OF DECEASED (Type or print) First Alexander Middle Plitas Last Plitas				4. DATE OF DEATH Month April Day 27 Year 1958			
5. SEX m	6. COLOR OR RACE w	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-96		9. AGE (In years last birthday) 61 yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ukraine		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sauva Plitas				14. MOTHER'S MAIDEN NAME Akilina Kahalnickska			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 078-26-1197		17. INFORMANT Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma Rt Lung 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right Pneumonectomy 4/21/58						INTERVAL BETWEEN ONSET AND DEATH 4 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 April, 1958 , to 27 April, 1958 , that I last saw the deceased alive on 26 April, 1958 , and that death occurred at 5:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED 4/27/58							
ACTUAL SIGNATURE William Newcomer M.D.				PHYSICIAN'S NAME (Type) William Newcomer, M.D. Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-30-58		22c. NAME OF CEMETERY OR CREMATORY CONSISTORY UCRANIAN ORTHODOX Church Cemetery		22d. LOCATION (City, town, or county) (State) South Bend Brook New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Philip E. Cwach				ADDRESS 2716 E. Monument St.		24a. REC'D BY REGISTRAR DATE APR 30 1958	
				24b. REGISTRAR'S SIGNATURE W. Leach			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED _____</p>		<p>2. SEX _____</p>		<p>3. AGE _____</p>	
<p>4. DATE OF DEATH _____</p>		<p>5. TIME OF DEATH _____</p>		<p>6. PLACE OF DEATH _____</p>	
<p>7. CAUSE OF DEATH _____</p>		<p>8. MANNER OF DEATH _____</p>		<p>9. SIGNATURE OF PHYSICIAN _____</p>	
<p>10. SIGNATURE OF REGISTRAR _____</p>		<p>11. SIGNATURE OF WITNESS _____</p>		<p>12. SIGNATURE OF DECEASED _____</p>	

BUREAU NO. 1

APR 30 1958

RECEIVED

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF JURY	

BUREAU V. 3

APR 15 1958

RECEIVED

4345

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6205 Windsor Mill Rd.</u>				d. STREET ADDRESS <u>6205 Windsor Mill Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>J.</u> Last <u>RAU</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>19 58</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 22, 1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>		IF UNDER 24 HRS. Months <u>72</u> Days <u>72</u> Hours <u>72</u> Min. <u>72</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Walter Schaefer</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Henry Rau</u>				14. MOTHER'S MAIDEN NAME <u>Mary Becker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Edith Rau - 6205 Windsor Mill Rd.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate with</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastasis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>?</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/14</u> , 19 <u>56</u> , to <u>4/4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/26</u> , 19 <u>58</u> , and that death occurred at <u>10:55</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4710 Liberty St. Bk</u> DATE SIGNED <u>APR 7 '58</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.							
PHYSICIAN'S NAME (Type) <u>[Signature]</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner & Sons - Baltimore</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 5 1953

RECEIVED

4346 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Falls		c. LENGTH OF STAY IN TB 45 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Franklinville Rd.		/d. STREET ADDRESS Franklinville Rd.	
3. NAME OF DECEASED (Type or print) First Lillian Middle V. Last Reynolds		4. DATE OF DEATH Month April Day 29 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Harford Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Hess		14. MOTHER'S MAIDEN NAME Jennie E. Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT William A. Reynolds		Address Upper Falls, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X INANITION DUE TO (b) CARCINOMA BREAST DUE TO (c) 6 mos. 6 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 6 mos. 6 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ORAL Sepsis - Ch. Polyanthrititis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CHOLELITHIASIS	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/27 , 19 58 , to 4/29 , 19 58 , that I last saw the deceased alive on 4/29 , 19 58 , and that death occurred at 2:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clifford F. Hudson		ADDRESS (Street, city or town, state) Fork Md.	
PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 2, 1958	22c. NAME OF CEMETERY OR CREMATORY Mountain Christian	22d. LOCATION (City, town, or county) (State) Mountain Rd. Harford Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REG. BY REGISTRAR SAI		24b. REGISTRAR'S SIGNATURE W. M. M. M.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

MADE IN U.S.A.

THE REGISTRAR

BRONX

1

<p>NAME OF DECEASED</p>		<p>AGE</p>	
<p>SEX</p>		<p>RACE</p>	
<p>DATE OF BIRTH</p>		<p>DATE OF DEATH</p>	
<p>PLACE OF BIRTH</p>		<p>PLACE OF DEATH</p>	
<p>RESIDENCE</p>		<p>CAUSE OF DEATH</p>	
<p>DATE OF INTERMENT</p>		<p>PLACE OF INTERMENT</p>	
<p>SIGNATURE OF REGISTRAR</p>		<p>SIGNATURE OF DECEASED</p>	
<p>DATE OF SIGNATURE</p>		<p>DATE OF SIGNATURE</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04330

4347 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		d. STREET ADDRESS 934 St. Agnes Lane	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle C. Last RICE		4. DATE OF DEATH Month April Day 21 Year 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 21, 1885
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob Maiers		14. MOTHER'S MAIDEN NAME Barbara -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mr. John J. Rice - 934 St. Agnes Lane, Balto.7		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Extreme hypertension and arteriosclerotic DUE TO cardiovascular disease (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 July 1953 to 20 April 1958 that I last saw the deceased alive on 20 April 1958 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 601 W. Main Way DATE SIGNED 21 April 58			
ACTUAL SIGNATURE Emil H Henning Jr M.D.		PHYSICIAN'S NAME (Type) EMIL H HENNING JR MD Baltimore 29 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/21/58	
22c. NAME OF CEMETERY OR CREMATORY Landon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons - Balt. 17 Md		24a. REC'D BY REGISTRAR DATE APR 22 '58	
24b. REGISTRAR'S SIGNATURE W. J. Tiekner			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

APR 23 1958

RECEIVED

4348 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 82 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS APT. 357 OAKLEIGH VILLAGE	
3. NAME OF DECEASED (Type or print) First HERBERT Middle L Last RILEY		4. DATE OF DEATH Month APRIL Day 9 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 26 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOILERMAKER		10b. KIND OF BUSINESS OR INDUSTRY STEEL	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EBEN RILEY		14. MOTHER'S MAIDEN NAME ELIZABETH WEBER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 215-07-4728	
17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA LEFT LUNG DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LAENNEC'S CIRRHOSIS		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS 6 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 17, 19 58 , to April 9, 19 58 , that last saw the deceased alive on 18 58 and that death occurred at 1:30 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jasper L. Van Avery M.D.		ADDRESS (Street, city or town, state) VAH FORT HOWARD MARYLAND DATE SIGNED 4-9-58	
PHYSICIAN'S NAME (Type) JASPER L VAN AVERY M.D.		VAH FORT HOWARD MARYLAND 4-9-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-12-58	
22c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE G. Truman Schwab Funeral Home ADDRESS		24a. REC'D BY REGISTRAR DATE APR 11 1958	
24b. REGISTRAR'S SIGNATURE Q. L. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4349

CERTIFICATE OF DEATH

04332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. LENGTH OF STAY IN 1b 30 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 448 Main Street				d. STREET ADDRESS 448 Main Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Russell Middle H. Last Robertson				4. DATE OF DEATH Month April Day 7 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1908		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Max L. Robertson				14. MOTHER'S MAIDEN NAME Martha Ellen Dunkle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Helen B. Robertson Address 448 Main Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastases to liver DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 8 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4-6-58 to 4-7-58 , that I last saw the deceased alive on 4-6-58 , and that death occurred at 3 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James G. Soffell M.D.				ADDRESS (Street, city or town, state) Reisterstown Md.			
PHYSICIAN'S NAME (Type) James G. Soffell				DATE SIGNED Reisterstown Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 10, 1958		22c. NAME OF CEMETERY OR CREMATORY All Saints		22d. LOCATION (City, town, or county) (State) Reisterstown, Baltimore Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home ADDRESS 3631 Falls Road				24a. REC'D BY REGISTRAR DATE APR 10 '58		24b. REGISTRAR'S SIGNATURE Quelch	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED		DATE OF DEATH	
Name of Deceased		Date of Death	
Age		Sex	
Race		Color	
Marital Status		Occupation	
Place of Birth		Place of Death	
Cause of Death		Manner of Death	
Physician's Signature		Registrar's Signature	
Date of Death		Time of Death	
Place of Death		City and State	
County		District	
Municipality		Ward	
Street		House No.	
City		State	
Country		Post Office	
Zip Code		Telephone No.	
Funeral Home		Burial Place	
Cemetery		Gravestone	
Date of Burial		Time of Burial	
Place of Burial		City and State	
County		District	
Municipality		Ward	
Street		House No.	
City		State	
Country		Post Office	
Zip Code		Telephone No.	

BUREAU V. 2

APR 10 1953

RECEIVED

APR 10 1953

4209 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4200 Hooper Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Arbutus d. STREET ADDRESS 4200 Hooper Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ella Gertrude Romans First Middle Last 4. DATE OF DEATH April 17 1958 Month Day Year		5. SEX FEMALE 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 4-3-1877 9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Balto. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frederick W. Niehoff 14. MOTHER'S MAIDEN NAME Mary E. Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. NONE 17. INFORMANT William M. Romans Address 4200 Hooper Ave.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Gangrene, both feet DUE TO (b) Arteriosclerosis DUE TO (c) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from January 1958 to April 17, 1958 , that I last saw the deceased alive on April 15, 1958 , and that death occurred at 10:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4508 Edmondson Village DATE SIGNED 4/17/58	
ACTUAL SIGNATURE D. C. McLaughlin PHYSICIAN'S NAME (Type) D. C. McLaughlin		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4-21-58 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery 22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Ave.		24a. READ BY REGISTRAR APR 19 58 DATE 24b. REGISTRAR'S SIGNATURE W. J. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased Howard N. Hubbard		Sex Male		Age 42-21-26	
Date of Death April 18 1952		Place of Death London Park Cemetery		City Boston	
Cause of Death 1st: Myocardial Infarction 2nd: Coronary Atherosclerosis		Occupation Salesman		Residence 1101 Wilkins Ave.	
Signature of Physician Dr. C. McLaughlin		Signature of Registrar [Signature]		Signature of Informant [Signature]	
Date of Report April 18 1952		City Boston		State Mass.	

BUREAU V. S.

APR 18 1952

RECEIVED

4350

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>HOUSE IN PINES</i>		d. STREET ADDRESS <i>2637 Loyola Northway</i>	
3. NAME OF DECEASED (Type or print) First <i>ROSE</i> Middle Last <i>RUBIN</i>		4. DATE OF DEATH Month <i>April</i> Day <i>29</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Not known</i>		14. MOTHER'S MAIDEN NAME <i>Pearl</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Samuel Silber</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260x Acute Coronary Occlusion</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Diabetes Mellitus</i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive Cardiovascular Disease</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Mar 21</i> , 1946, to <i>April 24</i> , 1958, that I last saw the deceased alive on <i>April 24</i> , 1958, and that death occurred at <i>10:30 P</i> .M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Samuel V. Tompakov</i>		ADDRESS (Street, city or town, state) <i>3600 Park Heights ave, Bkto, 15, Md.</i>	
PHYSICIAN'S NAME (Type) <i>SAMUEL V. TOMPAKOV, M.D.</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-30-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Rosedale</i>	22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i>		ADDRESS <i>2100 Eutaw Pl</i>	
24a. REC'D BY REGISTRAR <i>DAY</i>		24b. REGISTRAR'S SIGNATURE <i>Quench</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4351

CERTIFICATE OF DEATH

04335

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Northwind Road</u>		d. STREET ADDRESS <u>Box 341 Northwind Road</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. John Edward Sachs</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30th</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Theodore Sachs</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-07-9304</u>	
17. INFORMANT <u>Mr. Robert Warfield,</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Prostate with 177x</u> DUE TO (b) <u>Generalized Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 15, 1957</u> , to <u>Apr. 30, 1958</u> , that I last saw the deceased alive on <u>Apr. 30, 1958</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Nathan Lannoy</u> M.D.		ADDRESS (Street, city or town, state) <u>7101 Harford Rd.</u> DATE SIGNED <u>4/30/58</u>	
PHYSICIAN'S NAME (Type) <u>Nathan Lannoy</u>		<u>Baltimore, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/3/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 5 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. B. Ruck</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

EXAM BOARD

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS SURGERY	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS SURGERY	

4352 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>D.C.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sten Burnie</i> 02X-R			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in the Pines</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Sophia</i> Middle <i>Schaefer</i> Last <i>Schaefer</i>				4. DATE OF DEATH Month <i>April</i> Day <i>28</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 23/1884</i>	
9. AGE (If years last birthday) <i>73</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>John P. Schaefer</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>215-03-8112D</i>		17. INFORMANT <i>Norman Schaefer</i>		Address <i>403 Central Ave.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage, left.</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis, grossly</i> DUE TO (c) <i>Unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i> <i>8 yrs.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>30 Nov</i> 19 <i>46</i> , to <i>28 April</i> 19 <i>58</i> , that I last saw the deceased alive on <i>23 April</i> 19 <i>58</i> , and that death occurred at <i>7:30 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Howard Goodman</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>1513 N. Millman Ave. Balto B Md.</i>			
PHYSICIAN'S NAME (Type) <i>HOWARD GOODMAN</i>				<i>Balto B Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/1/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John C. Milne Inc</i>				ADDRESS <i>2431-35 E. Oliver St.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 30 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>W. L. ...</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

John T. Fisher
 312-03-8153
 403 Central Ave.
 Baltimore, Md.
 April 28, 1938
 403 Central Ave.
 Baltimore, Md.

RECEIVED
 APR 30 1938
 BUREAU X. 1

John T. Fisher
 312-03-8153
 403 Central Ave.
 Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4353 CERTIFICATE OF DEATH

04337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 20 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				d. STREET ADDRESS 349 YALE AVE			
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE E. SCHMIDT				4. DATE OF DEATH Month Day Year APRIL 13 1958			
5. SEX FE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-18-1874	
9. AGE (In years last birthday) 83 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME HENRY PAAR RUBEN SCHMIDT		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Frank R. Smith Jr. Address Cockeysville Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-Sclerotic Cardio 422J DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 15 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19			
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3-26, 1958 , to 4-11, 1958 , that I last saw the deceased alive on 4/11/58 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter T. Kees				M.D. Cockeysville, Md.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 15, 1958		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.				ADDRESS 1217 St. Paul Street		24a. REC'D BY REGISTRAR APR 15 58	
24b. REGISTRAR'S SIGNATURE W. T. Kees							

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore 4354 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore Alleg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills Midland 01X-2 d. STREET ADDRESS Church St. Rosewood State Training Sch. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAYMOND Middle EDWARD Last SCHURG		4. DATE OF DEATH Month April Day 11 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/20/1937
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR Months 0 Days 11	IF UNDER 24 HRS. Hours 19 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never worked		10b. KIND OF BUSINESS OR INDUSTRY Midland, Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Raymond Schurg		14. MOTHER'S MAIDEN NAME Virginia Hunt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Eichorn Funeral Home		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to Hanging 936.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) 936.6 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 936.6			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Undetermined	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 4/10/58 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods		20f. (City or town) Owings Mills (County) Baltimore (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/58	
22c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		22d. LOCATION (City, town, or county) Frostburg, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickover Sons		24a. REC'D BY REGISTRAR APR 15 '58	
ADDRESS Balto - 17, Md.		24b. REGISTRAR'S SIGNATURE Wm. J. Pickover	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Guerin advised, Code "Suicide"

BUREAU V. S.

APR 16 1958

RECEIVED

4355

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freeland.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Freeland.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Millers Mill Rd.</u>		d. STREET ADDRESS <u>Millers Mill Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>Ann</u> Last <u>Seitz.</u>		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1958.</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Febr. 16, 1880</u>
9. AGE (In years last birthday) yrs. <u>78.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home.</u>	
11. BIRTHPLACE (State or foreign country) <u>Freeland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lewis W. Daugherty.</u>		14. MOTHER'S MAIDEN NAME <u>Sarah A. Wilson.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>C</u>	
17. INFORMANT <u>Lawrence Seitz.</u>		Address <u>Freeland Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-27</u> , 19 <u>58</u> , to <u>4-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-21</u> , 19 <u>58</u> , and that death occurred at <u>4:00 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis Schatanoff</u> M.D.		ADDRESS (Street, city or town, state) <u>New Freedom Pa</u> DATE SIGNED <u>4/23/58</u>	
PHYSICIAN'S NAME (Type) <u>Louis Schatanoff, M.D.</u>		<u>New Freedom, York Co., Penn a.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/24/58.</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Maryland Line Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Maryland Line Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Horstenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>Alberich</u>		24b. REGISTRAR'S SIGNATURE <u>Alberich</u>	
DATE <u>APR 24 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1. NAME OF DECEASED J. H. SMITH		2. SEX Male		3. AGE 65		4. DATE OF DEATH April 1, 1954	
5. PLACE OF DEATH Home		6. CITY Baltimore		7. COUNTY Baltimore		8. STATE Maryland	
9. OCCUPATION Retired		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. H. SMITH	
13. SIGNATURE OF DECEASED J. H. SMITH		14. SIGNATURE OF WITNESSES J. H. SMITH		15. SIGNATURE OF REGISTRAR J. H. SMITH		16. SIGNATURE OF CLERK J. H. SMITH	
17. SIGNATURE OF MINISTER OF THE GOSPEL J. H. SMITH		18. SIGNATURE OF CHURCH CLERK J. H. SMITH		19. SIGNATURE OF BURIAL CLERK J. H. SMITH		20. SIGNATURE OF FUNERAL HOME J. H. SMITH	
21. SIGNATURE OF CORONER J. H. SMITH		22. SIGNATURE OF JURY J. H. SMITH		23. SIGNATURE OF JUDGE J. H. SMITH		24. SIGNATURE OF CLERK J. H. SMITH	
25. SIGNATURE OF DECEASED J. H. SMITH		26. SIGNATURE OF WITNESSES J. H. SMITH		27. SIGNATURE OF REGISTRAR J. H. SMITH		28. SIGNATURE OF CLERK J. H. SMITH	
29. SIGNATURE OF MINISTER OF THE GOSPEL J. H. SMITH		30. SIGNATURE OF CHURCH CLERK J. H. SMITH		31. SIGNATURE OF BURIAL CLERK J. H. SMITH		32. SIGNATURE OF FUNERAL HOME J. H. SMITH	
33. SIGNATURE OF CORONER J. H. SMITH		34. SIGNATURE OF JURY J. H. SMITH		35. SIGNATURE OF JUDGE J. H. SMITH		36. SIGNATURE OF CLERK J. H. SMITH	
37. SIGNATURE OF DECEASED J. H. SMITH		38. SIGNATURE OF WITNESSES J. H. SMITH		39. SIGNATURE OF REGISTRAR J. H. SMITH		40. SIGNATURE OF CLERK J. H. SMITH	
41. SIGNATURE OF MINISTER OF THE GOSPEL J. H. SMITH		42. SIGNATURE OF CHURCH CLERK J. H. SMITH		43. SIGNATURE OF BURIAL CLERK J. H. SMITH		44. SIGNATURE OF FUNERAL HOME J. H. SMITH	
45. SIGNATURE OF CORONER J. H. SMITH		46. SIGNATURE OF JURY J. H. SMITH		47. SIGNATURE OF JUDGE J. H. SMITH		48. SIGNATURE OF CLERK J. H. SMITH	
49. SIGNATURE OF DECEASED J. H. SMITH		50. SIGNATURE OF WITNESSES J. H. SMITH		51. SIGNATURE OF REGISTRAR J. H. SMITH		52. SIGNATURE OF CLERK J. H. SMITH	
53. SIGNATURE OF MINISTER OF THE GOSPEL J. H. SMITH		54. SIGNATURE OF CHURCH CLERK J. H. SMITH		55. SIGNATURE OF BURIAL CLERK J. H. SMITH		56. SIGNATURE OF FUNERAL HOME J. H. SMITH	
57. SIGNATURE OF CORONER J. H. SMITH		58. SIGNATURE OF JURY J. H. SMITH		59. SIGNATURE OF JUDGE J. H. SMITH		60. SIGNATURE OF CLERK J. H. SMITH	
61. SIGNATURE OF DECEASED J. H. SMITH		62. SIGNATURE OF WITNESSES J. H. SMITH		63. SIGNATURE OF REGISTRAR J. H. SMITH		64. SIGNATURE OF CLERK J. H. SMITH	
65. SIGNATURE OF MINISTER OF THE GOSPEL J. H. SMITH		66. SIGNATURE OF CHURCH CLERK J. H. SMITH		67. SIGNATURE OF BURIAL CLERK J. H. SMITH		68. SIGNATURE OF FUNERAL HOME J. H. SMITH	
69. SIGNATURE OF CORONER J. H. SMITH		70. SIGNATURE OF JURY J. H. SMITH		71. SIGNATURE OF JUDGE J. H. SMITH		72. SIGNATURE OF CLERK J. H. SMITH	
73. SIGNATURE OF DECEASED J. H. SMITH		74. SIGNATURE OF WITNESSES J. H. SMITH		75. SIGNATURE OF REGISTRAR J. H. SMITH		76. SIGNATURE OF CLERK J. H. SMITH	
77. SIGNATURE OF MINISTER OF THE GOSPEL J. H. SMITH		78. SIGNATURE OF CHURCH CLERK J. H. SMITH		79. SIGNATURE OF BURIAL CLERK J. H. SMITH		80. SIGNATURE OF FUNERAL HOME J. H. SMITH	
81. SIGNATURE OF CORONER J. H. SMITH		82. SIGNATURE OF JURY J. H. SMITH		83. SIGNATURE OF JUDGE J. H. SMITH		84. SIGNATURE OF CLERK J. H. SMITH	
85. SIGNATURE OF DECEASED J. H. SMITH		86. SIGNATURE OF WITNESSES J. H. SMITH		87. SIGNATURE OF REGISTRAR J. H. SMITH		88. SIGNATURE OF CLERK J. H. SMITH	
89. SIGNATURE OF MINISTER OF THE GOSPEL J. H. SMITH		90. SIGNATURE OF CHURCH CLERK J. H. SMITH		91. SIGNATURE OF BURIAL CLERK J. H. SMITH		92. SIGNATURE OF FUNERAL HOME J. H. SMITH	
93. SIGNATURE OF CORONER J. H. SMITH		94. SIGNATURE OF JURY J. H. SMITH		95. SIGNATURE OF JUDGE J. H. SMITH		96. SIGNATURE OF CLERK J. H. SMITH	
97. SIGNATURE OF DECEASED J. H. SMITH		98. SIGNATURE OF WITNESSES J. H. SMITH		99. SIGNATURE OF REGISTRAR J. H. SMITH		100. SIGNATURE OF CLERK J. H. SMITH	

BUREAU V. S.

APR 1

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4356 CERTIFICATE OF DEATH

04340

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Howard		c. LENGTH OF STAY IN lb 41 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4 ✓	
f. STREET ADDRESS 110 North Wolfe Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle S. (Serisier) Last SERISIS		4. DATE OF DEATH Month April Day 15 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 25, 1885
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Ship Building	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Serisis		14. MOTHER'S MAIDEN NAME Fannie Grane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 219-01-4816	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INFARCTION OF MYOCARDIUM 420.1 DUE TO CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 MIN. 15 MIN.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Benign prostatic hypertrophy- 2 yrs. 2. Right hydrocele- unknown dur. Suprapubic prostatectomy- 3/24/58. Hydrocelectomy 4/10/58		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 5 , 19 58 , to April 15 , 19 58 . He died on the day of his death and that death occurred at 1:48 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Joseph M. Miller M.D. VA HOSPITAL, FORT HOWARD, MD. 4/16/58			
PHYSICIAN'S NAME (Type) JOSEPH M. MILLER, M.D., Chief, Surgical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April-18-58	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Elroy Wilson Funeral Home, 1000 Brantley Ave.		24a. REC'D BY REGISTRAR DATE APR 22 '58	24b. REGISTRAR'S SIGNATURE W. H. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. S.

APR 23 1933

RECEIVED

4357

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Shaeffer</u> Last <u>Shaeffer</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Stewartstown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Aguilla Edie</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Garfield Shaeffer, White Hall Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension C. V. Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1956</u> , to <u>ap. 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>ap. 9</u> , 19 <u>58</u> , and that death occurred at <u>10:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>Parkton, Md.</u> DATE SIGNED <u>4/11/58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. A. M. France</u>		<u>Parkton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Liberty Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u> DATE <u>APR 14 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MEDICAL HISTORY		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4358 CERTIFICATE OF DEATH

04342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1708 Hill Drive</u>				d. STREET ADDRESS <u>1708 Hill Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIAN</u> <u>O.</u> <u>SHAFFER</u>				4. DATE OF DEATH Month Day Year <u>April</u> <u>13</u> , 19 <u>58</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1895</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Anna Geschwind</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. J. Lloyd Shaffer - 1708 Hill Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-10</u> , 19 <u>55</u> , to <u>4-13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-26</u> , 19 <u>58</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John F. Schaefer</u>				ADDRESS (Street, city or town, state) <u>401 RANDOLPH RD. BALTO. 29 MD.</u>		DATE SIGNED <u>4-14-58</u>	
PHYSICIAN'S NAME (Type) <u>JOHN F. SCHAEFER M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4-14-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parson's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Parsons, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner</u>				ADDRESS <u>401 Randolph Rd. Baltimore</u>		24a. REC'D BY REGISTRAR DATE <u>APR 15 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Qu...</u>			

1938 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. RACE</p>	
<p>5. DATE OF BIRTH</p>		<p>6. PLACE OF BIRTH</p>	
<p>7. DATE OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF DECEASED</p>	

RECEIVED
APR 16 1938
BURKAV V. S.



For full details of the laws governing the registration of deaths, see the Maryland State Department of Health, Baltimore, Maryland, 1938.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4359 CERTIFICATE OF DEATH

04343

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6131 N. Charles Street Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edna Middle I. Last Shannon		4. DATE OF DEATH Month April Day 22 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1878
9. AGE (In years last birthday) yrs. 79		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Small		14. MOTHER'S MAIDEN NAME Eloise Hull	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT W.R. Stevens, 6131 N. Charles Street Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral-Vascular Disease 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 22, 1958 to April 22, 1958 , that I last saw the deceased alive on April 22, 1958 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert J. Shochat M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 4111 Liberty Street 4/22/58	
PHYSICIAN'S NAME (Type) Albert J. Shochat M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 4-23-58	
22c. NAME OF CEMETERY OR CREMATORY Cypress Hills Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn, New York	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1210 St. Paul Street		24a. REC'D BY REGISTRAR DATE APR 25 '58	
		24b. REGISTRAR'S SIGNATURE W. H. ...	

CERTIFICATE OF DEATH

Name of Deceased John W. Jones		Age 45		Sex Male		Race White		Date of Death Dec 10, 1938		Place of Death New York		Cause of Death Heart Disease		Manner of Death Natural		Signature of Physician J. W. Jones		Signature of Registrar J. W. Jones	
Residence 1234 Main St., Baltimore, Md.		Occupation Teacher		Marital Status Married		Religion Roman Catholic		Date of Birth Jan 1, 1893		Place of Birth New York		Cause of Death Heart Disease		Manner of Death Natural		Signature of Physician J. W. Jones		Signature of Registrar J. W. Jones	
Name of Deceased John W. Jones		Age 45		Sex Male		Race White		Date of Death Dec 10, 1938		Place of Death New York		Cause of Death Heart Disease		Manner of Death Natural		Signature of Physician J. W. Jones		Signature of Registrar J. W. Jones	
Residence 1234 Main St., Baltimore, Md.		Occupation Teacher		Marital Status Married		Religion Roman Catholic		Date of Birth Jan 1, 1893		Place of Birth New York		Cause of Death Heart Disease		Manner of Death Natural		Signature of Physician J. W. Jones		Signature of Registrar J. W. Jones	

BUREAU V. S.

1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 "C.D." report card. 6-9-58 ams

4360 CERTIFICATE OF DEATH

Reg. Dist. No.

04344

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>9 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>604 W. Mulberry Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>----</u> Last <u>SINGLETARY</u>				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1893</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Burner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Savage, S. Carolina</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Singletary</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MILIARY TUBERCULOSIS (Lungs involved)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>002X</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 12</u> , 19 <u>58</u> , to <u>April 21</u> , 19 <u>58</u> , and that death occurred at <u>1:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Abraham A. Polachek, M.D.</u>				DATE SIGNED <u>4/21/58</u>			
PHYSICIAN'S NAME (Type) <u>ABRAHAM A. POLACHEK, M.D., Acting Chief, Medical Service</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy Wilson Funeral Home, 1000 Brantley Ave. Balto. Md.</u>				24a. REC'D BY REGISTRAR <u>APR 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

APR 28 1953

RECEIVED

4361 CERTIFICATE OF DEATH

Reg. Dist. No. 04345

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 TOWSON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 234 RIDGE AVE.		d. STREET ADDRESS 234 RIDGE AVE.	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD M. SLACUM		4. DATE OF DEATH Month Day Year APRIL 16, 1958 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1878
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Fitter Helper		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Slacum		14. MOTHER'S MAIDEN NAME Pricilla ???	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 216-10-4895	
17. INFORMANT Mrs Barbara Slacum		Address 234 Ridge Ave, Towson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443x IMMEDIATE CAUSE (a) Hypertensive-Arteriosclerotic CARDIO-VASCULAR DISEASE - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 YRS -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-11, 1958 to 4-16, 1958 , that I last saw the deceased alive on 4-15, 1958 , and that death occurred at 7:30 A M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 5217 YORK Rd		DATE SIGNED BA) to 12 md	
ACTUAL SIGNATURE Anthony F. Carozza		M.D.	
PHYSICIAN'S NAME (Type) Anthony F. Carozza			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 19, 1958	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemt	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		24a. REC'D BY REGISTRAR APR 18 '58	
ADDRESS 3000 E. Baltimore St.		24b. REGISTRAR'S SIGNATURE W. H. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4362 CERTIFICATE OF DEATH

04346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>	
c. LENGTH OF STAY IN 1b <u>55 yrs.</u>		d. STREET ADDRESS <u>111 WAMPLER Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LY-Y-HALL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN PAUL SMITH</u>		4. DATE OF DEATH <u>4 - 19 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 12 - 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>13</u> Hours <u>15</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO-BRICK CO</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN SMITH</u>		14. MOTHER'S MAIDEN NAME <u>ASHMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-01-396</u>	
17. INFORMANT <u>WIFE</u>		Address <u>SAME</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Sigmoid</u> DUE TO (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>58</u> , to <u>April 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 19</u> , 19 <u>58</u> , and that death occurred at <u>7 PM</u> , M, from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>JM Baumgardner</u> M.D.		DATE SIGNED <u>4/21/58</u>
PHYSICIAN'S NAME (Type) <u>BALTO 6 MD</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/22/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood-Cem</u>
22d. LOCATION (City, town, or county) <u>BALTO</u>		(State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Emelly - Essex</u>		24a. REC'D BY REGISTRAR <u>DATE APR 23 '58</u>
ADDRESS <u>Essex Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>

CERTIFICATE OF DEATH

DATE OF DEATH

STATE OF MARYLAND

COUNTY

DECEASED

CAUSE

SEX

AGE

DATE

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS MARRIAGES

PREVIOUS DEATHS

PREVIOUS MENTAL ILLNESS

PREVIOUS PHYSICAL ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS INJURY

PREVIOUS DISEASE

PREVIOUS TREATMENT

PREVIOUS MEDICATION

PREVIOUS DIAGNOSIS

BUREAU V. S.

APR 23 1938

RECEIVED

4210

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Dennis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Dennis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1728 River Rd.		d. STREET ADDRESS 1728 River Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret K. Middle Smith Last		4. DATE OF DEATH Month April Day 22 Year 1958	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-29-1893
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Tudon		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-05-0608A	
17. INFORMANT Almer H. Smith		Address 1728 River Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Coronary Occlusion & DUE TO (c) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 55 , to April 22 , 19 58 , that I last saw the deceased alive on April 20 , 19 58 , and that death occurred at 5:45 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Healy M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Howard H. Hubbard, Md 4/24/58	
PHYSICIAN'S NAME (Type) Dr. John C. Healy			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-24-58	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.		22d. LOCATION (City, town, or county) (State) Howard County Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.	
24a. REC'D BY REGISTRAR DATE APR 28 '58		24b. REGISTRAR'S SIGNATURE Al H. Smith	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Date

No.

Age

Sex

Place of Birth

Place of Death

1700 River St.

Margaret H. Smith

April 28, 1958

0-42-100

Female

White, MA.

Houseside

1900

John T. Smith

Almer H. Smith 1700 River St.

0-42-100

BUREAU V. 2

APR 28 1958

RECEIVED

Howard C. Smith

Mendocino Co. Cal.

Dr. John C. Smith

0-42-100

Howard H. Hubbard 107 Wilkins Ave.

4363 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>208 Park Drive</u>				d. STREET ADDRESS <u>208 Park Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>FREDERICK</u> Last <u>SMITH, SR.</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>19 58</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1, 1864</u>		9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. William F. Smith, Jr. - 208 Park Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 da.</u> <u>15 3/4</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-10</u> , 19 <u>54</u> to <u>4-19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-18</u> , 19 <u>58</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6209 Frederick Ave. Baltimore, Md.</u> DATE SIGNED <u>4-21-58</u>							
ACTUAL SIGNATURE <u>Wilmer K. Gallager</u>				M.D. <u>6209 Frederick Ave. Baltimore, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager</u>				<u>Baltimore, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Vickner & Son - Balt</u>				24a. REC'D BY REGISTRAR DATE <u>APR 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1958

RECEIVED

(also Louise Stalfort)

4364 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		b. COUNTY Balto.	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6816 Blenheim Rd.		d. STREET ADDRESS 6816 Blenheim Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LOUISE		4. DATE OF DEATH Month April , Day 5 , Year 19 58	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 27, 1886	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James R. Degges		14. MOTHER'S MAIDEN NAME Louise Bacon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Louis J. Smrcina - 6816 Blenheim Rd. Towson		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertrophic Cirrhosis of Liver. 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Alcoholism DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH months? years?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio-sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 27, 1958, to April 5, 1958 , that I last saw the deceased alive on April 4, 1958 , and that death occurred at 24 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Frank N. Ogden M.D. 2701 N. Calvert St. Balto. 18, Md. Apr. 5, 1958 PHYSICIAN'S NAME (Type) FRANK N. OGDEN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/58	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto 17		24a. REC'D BY REGISTRAR DATE APR 9 '58	
24b. REGISTRAR'S SIGNATURE Overman			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU V. S.

8261 6 Yd.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film 228 5-5-58 et

4365

CERTIFICATE OF DEATH

04350

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Inwood Road #7				d. STREET ADDRESS Inwood Road #7			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) HANS First SOLLI Middle SOLLI Last				4. DATE OF DEATH April 25 Month 1958 Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 7, 1891	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Norway	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. George Solli-8101 Barnsdale Road- #4 Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with generalized metastases DUE TO (c) spontaneous							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) spontaneous							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15, 1958 to Apr 25, 1958 that I last saw the deceased alive on Apr 25, 1958 and that death occurred at 6:35 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE M. Paul Byerly M.D.				ADDRESS (Street, city or town, state) 3033 W. North DATE SIGNED Apr 16, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/58		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker ADDRESS Balto - 17, Md.				24a. REC'D BY REGISTRAR APR 28 '58		24b. REGISTRAR'S SIGNATURE W. J. Tucker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

4366 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 35 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6505 Hazelwood Court				d. STREET ADDRESS 6505 Hazelwood Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard		First Kenneth		Middle Spalding		Last	
4. DATE OF DEATH April 28-1958		Month 19		Day 19		Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-1897		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Glen Martin Co.		11. BIRTHPLACE (State or foreign country) Point of Rocks, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard J. Spalding				14. MOTHER'S MAIDEN NAME Pattie Nichols			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-18-5275		17. INFORMANT Mrs. Nettie Spalding 6505 Hazelwood Court			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 7 min. 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 4 , 19 55 , to APRIL 25 , 19 58 , that I last saw the deceased alive on APRIL 25 , 19 58 , and that death occurred at 7:42 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE James R. Mason, M.D.		M.D.					
PHYSICIAN'S NAME (Type)		James R. Mason, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-1958		22c. NAME OF CEMETERY OR CREMATORY Landon Pk. Cemetery		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Fun'l Home				ADDRESS 7404 Belair Rd.		24a. REC'D BY REGISTRAR APR 30 '58	
				24b. REGISTRAR'S SIGNATURE W. L. Search			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. B.

APR 30 1958

RECEIVED

4367 CERTIFICATE OF DEATH

04352

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
c. LENGTH OF STAY IN 1b <u>7 yrs.</u>		52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>419 Whitfield Road</u>		d. STREET ADDRESS <u>419 Whitfield Road</u>	
3. NAME OF DECEASED (Type or print) <u>IDA-EUGENE SPARKS</u>		4. DATE OF DEATH <u>April 15 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Levi Sparks</u>		14. MOTHER'S MAIDEN NAME <u>Belia Lineweaver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Margaret A. Hughes</u>		Address <u>419 Whitfield Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio- Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 24</u> , 1956, to <u>April</u> , 1958, that I lost saw the deceased alive on <u>March 3</u> , 1958, and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jos J. Gaver</u> M.D.		ADDRESS (Street, city or town, state) <u>1 Mallow Hill Ave., Baltimore 29, Maryland.</u>	
DATE SIGNED <u>4/15/58</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 17-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Geyfel</u>		24a. REC'D BY REGISTRAR <u>West</u>	
ADDRESS <u>5311 Edmondson Ave</u>		24b. REGISTRAR'S SIGNATURE <u>West</u>	
DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

George

FLAM RECORD

BUREAU V. S.

Aug 17 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04353

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>N. Y.</u> b. COUNTY <u>Westchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>1 wk.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Plains</u> 69X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Marnettville, Road</u>				d. STREET ADDRESS <u>98 Harding Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>O.</u> Last <u>Sweeney</u>				4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19, 1923</u>	
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of City</u>		11. BIRTHPLACE (State or foreign country) <u>N. Y. City N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frank Sweeney</u>				14. MOTHER'S MAIDEN NAME <u>Mary Donovan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>WW 11</u>		17. INFORMANT <u>Daniel Sweeney</u> Address <u>White Plains, N. Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C. V. Disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury - Found dead in bed.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>None</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D. D. Caples</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-15, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Town of Greenburgh, N. Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>				24a. REC'D BY REGISTRAR <u>15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Qu. Lewis</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
APR 16 1958
BUREAU V. S.

CHIEF OF BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04354

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

4211

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Port News 83x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore-Washington Expressway.		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First GEORGE Middle SWEENIE Last SWEENIE		4. DATE OF DEATH Month April Day 16 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-16
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Truck driver	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Arthur H. Swennie.		14. MOTHER'S MAIDEN NAME Annie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Watson King Address Rockingham N.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing Injury of Chest with Transection of Thoracic Aorta. 816x Conditions, if any, which gave rise to immediate cause (b) XXXXX (a), stating the underlying cause last. (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of tractor trailer which ran into back of another truck.	
20c. TIME OF INJURY Month, Day, Year Hour 3:43 o. m. xxx 4/16 1958	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) Halethorpe (County) Baltimore (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin,		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-19-58	22c. NAME OF CEMETERY OR CREMATORY Diggs Chapel	22d. LOCATION (City, town, or county) Rockingham N. C. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard ADDRESS 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR DATE APR 17 '58 24b. REGISTRAR'S SIGNATURE Olden	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be retained for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17 1938

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

Item 18 Film 220 3-4-56

4199

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 53 Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6800 Morington Road		d. STREET ADDRESS 311 - Apt. A, Wise Avenue	
3. NAME OF DECEASED (Type or print) MELVIN DALE TANNER		4. DATE OF DEATH Month April Day 15 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1958
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	IF UNDER 24 HRS. Hours 3 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Melvin D. Tanner		14. MOTHER'S MAIDEN NAME Mary Parks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Melvin D. Tanner, 311 Apt. A. Wise Ave.	
17. INFORMANT Melvin D. Tanner, 311 Apt. A. Wise Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 501X Tracheobronchitis with Bronchopneumonia. DUE TO Conditions, if any, which gave rise to immediate cause (b) 501X (stating the underlying cause lost.) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/16/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 17, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ullrich Funeral Home 2112 Dundalk Ave.		24a. REC'D BY REGISTRAR APR 21 '58	
24b. REGISTRAR'S SIGNATURE Paul F. Guerin			

2035-171XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAXYLAND STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



BUREAU V. S.

APR 21 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04356

4200 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3435 LIBERTY PKWY</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>URED</u> Middle <u>WILLIAMS</u> Last <u>TATE</u>				4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 5, 1886</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>BENJ. WILLIAMS</u>				14. MOTHER'S MAIDEN NAME <u>ELIZ. HOLLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HARVEY R. TATE - SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>13 hrs</u> <u>15 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 195 <u>5</u> , to <u>4-19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-18</u> , 19 <u>58</u> , and that death occurred at <u>3:30</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jack C Collins</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>2 Kinship</u> <u>Baet 22 md</u>			
PHYSICIAN'S NAME (Type) <u>Jack C Collins</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SYLVAN HERS.</u>		22d. LOCATION (City, town, or county) (State) <u>UNION TOWN, PENNA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Smith Dudley, Dundalk, MD</u>				24a. REC'D BY REGISTRAR <u>APR 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Smith</u>	

BUREAU V. S.

APR 21 1958

RECEIVED

4369 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VA. b. COUNTY ACCOMAC	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 1 1/2 MON.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 Osborne Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TEMPERANCEVILLE	
3. NAME OF DECEASED (Type or print) First AGNES Middle HARTMAN Last TAYLOR		4. DATE OF DEATH Month 4 Day 10 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 27/1884
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB HARTMAN		14. MOTHER'S MAIDEN NAME SALLY NORTHAM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT DAUGHTER - GRACE WEHNER		Address 105 OSBORN CATONSVILLE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTEROSCLEROTIC C. V. D. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 1943 to Apr 10, 1958 , that I last saw the deceased alive on Apr 9, 1958 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3325 Frederick Ave Baltimore Md. DATE SIGNED			
ACTUAL SIGNATURE J. C. Pound		PHYSICIAN'S NAME (Type) J. C. Pound	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	22b. DATE THEREOF 4-10-58	22c. NAME OF CEMETERY OR CREMATORY John W. Taylor Memorial	22d. LOCATION (City, town, or county) (State) Belle Haven, Accomac Co., Va
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE APR 11 '58	24b. REGISTRAR'S SIGNATURE W. H. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 11 1959

RECEIVED

4370 CERTIFICATE OF DEATH

04358

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown, near</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville</u> 12x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Almacost Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ida Virginia Taylor</u>			4. DATE OF DEATH Month <u>Apr</u> Day <u>26</u> Year <u>1958</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1862</u>	9. AGE (In years last birthday) <u>95</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u></u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Jarrettsville Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13. FATHER'S NAME <u>WM Bosley Jarrett</u>			14. MOTHER'S MAIDEN NAME <u>Mary Virginia Cairnes</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Charles H. Taylor, Jarrettsville Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic-Hypertensive HT. Disease</u> DUE TO (c) <u>LOBAR PNEUMONIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 weeks</u> <u>15 years</u> <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490X Senility</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> 19 <u>57</u> , to <u>April 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 25</u> , 19 <u>58</u> , and that death occurred at <u>8:15 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Jarrettsville, Md.</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>S. James Thomison, Jr.</u>			M.D. <u>Jarrettsville, Md.</u>				
PHYSICIAN'S NAME (Type) <u>S. JAMES THOMISON, Jr., M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jarrettsville</u>		22d. LOCATION (City, town, or county) (State) <u>Jarrettsville Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Skurty Jarrettsville</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Quelch</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4371

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. <i>Q.Q.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Linthicum Hgts. <i>02X-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nellie Middle Theresa Last Taylor		4. DATE OF DEATH Month April Day 22 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1882
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) telephone operator		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Taylor		14. MOTHER'S MAIDEN NAME Theresa Lamb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-05-1169	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis, severe DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan, 20 , 19 58 , to April 22 , 19 58 , that I last saw the deceased alive on April 22 , 19 58 , and that death occurred at 3:00a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 4-22-58			
ACTUAL SIGNATURE Stella Wachslar M.D.		PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/58	
22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cem.		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mr. J. L. Lickner & Sons - Balto		24a. REC'D BY REGISTRAR DATE APR 23 '58	
24b. REGISTRAR'S SIGNATURE W. L. Lickner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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RECEIVED

APR 24 1958

BUREAU V. S.

Reg. Dist. No.

4372

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death:

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

MAITLAND STATE DEPARTMENT OF HEALTH - BALTIMORE - MD

DATE OF DEATH

DECEASED'S NAME

DECEASED'S RESIDENCE

DECEASED'S SEX AND AGE

DECEASED'S OCCUPATION

DECEASED'S MARITAL STATUS

DECEASED'S RACE

DECEASED'S BIRTH DATE

DECEASED'S BIRTH PLACE

DECEASED'S BIRTH COUNTRY

DECEASED'S BIRTH STATE

DECEASED'S BIRTH CITY

DECEASED'S BIRTH COUNTY

DECEASED'S BIRTH ZIP CODE

DECEASED'S BIRTH STATE

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DECEASED'S BIRTH STATE

DECEASED'S BIRTH CITY

DECEASED'S BIRTH COUNTY

DECEASED'S BIRTH ZIP CODE

BUREAU V. S.

APR 15 1959

RECEIVED

4373

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7306 Liberty Road				d. STREET ADDRESS 3811 Gwynn Oak Avenue #7			
3. NAME OF DECEASED (Type or print) First Middle Last WALLACE A. THOMAS, Sr.				4. DATE OF DEATH Month Day Year 4 11 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 29, 1888		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired V.P.		10b. KIND OF BUSINESS OR INDUSTRY Western Md. Dairy		11. BIRTHPLACE (State or foreign country) Aquaso, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wallace A. Thomas				14. MOTHER'S MAIDEN NAME Alma Hunter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes		17. INFORMANT Address Mrs. Clara D. Thomas-3811 Gwynn Oak Avenue #7			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Oct. 1947 , to April 11, 1958 , that I last saw the deceased alive on March 27, 1958 , and that death occurred at 4:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Earl L. Chambers		M.D. 4108 Liberty Hts Ave - Balto - Md		ADDRESS (Street, city or town, state)		DATE SIGNED 4-13-58	
PHYSICIAN'S NAME (Type) Earl L. Chambers		4108 Liberty Hts Ave - Balto - Md		4-13-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/58		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker & Sons				ADDRESS Balto - 17 Md.		24a. REC'D BY REGISTRAR DATE APR 15 '58	
				24b. REGISTRAR'S SIGNATURE Wm. J. Tucker & Sons			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 16 1953

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]

2. SEX: [illegible]

3. AGE: [illegible]

4. DATE OF BIRTH: [illegible]

5. PLACE OF BIRTH: [illegible]

6. OCCUPATION: [illegible]

7. CAUSE OF DEATH: [illegible]

8. DATE OF DEATH: [illegible]

9. PLACE OF DEATH: [illegible]

10. SIGNATURE OF REGISTRAR: [illegible]

11. SIGNATURE OF PHYSICIAN: [illegible]

12. SIGNATURE OF FUNERAL HOME: [illegible]

13. SIGNATURE OF WITNESS: [illegible]

14. SIGNATURE OF DECEASED: [illegible]

15. SIGNATURE OF NEXT OF KIN: [illegible]

16. SIGNATURE OF CLERGYMAN: [illegible]

17. SIGNATURE OF CHURCH: [illegible]

18. SIGNATURE OF BURIAL PLACE: [illegible]

19. SIGNATURE OF CREMATORIUM: [illegible]

20. SIGNATURE OF OTHER: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

4201

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> <u>Dundalk</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Turner Station</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>201 Walnut Avenue</u>		d. STREET ADDRESS <u>201 Walnut Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Fletcher</u> Middle <u>Toney</u> Last <u>Toney</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1887</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>	IF UNDER 24 HRS. Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steelworker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Roanoke Rapids, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Osborne Toney</u>		14. MOTHER'S MAIDEN NAME <u>Martha Toney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-2327</u>	
17. INFORMANT <u>C. Milton Toney</u>		Address <u>201 Walnut Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO <u>Hypertension</u> (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>April 2nd 1958</u> , to <u>April 2nd 1958</u> , that I last saw the deceased alive on <u>April 2nd 1958</u> , and that death occurred at <u>10 77 Main St. Baltimore 22nd</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Thomas</u>		DATE SIGNED <u>10 77 Main St. Baltimore 22nd</u>	
PHYSICIAN'S NAME (Type) <u>J. H. Thomas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE HEREOF <u>4-5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		ADDRESS <u>802 Madison Avenue</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PR 7 1958

RECEIVED

4374 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>and</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <u>Catonsville</u>	
c. LENGTH OF STAY IN 1b <u>25 yrs</u>		d. STREET ADDRESS <u>5702 Edmondson Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>5702 Edmondson Ave</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELEANOR-ANNA-TRINKAUS</u>		4. DATE OF DEATH <u>April 23</u> 19 <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1887</u> 19 <u>70</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Times Optical Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry J. Trinkaus</u>		14. MOTHER'S MAIDEN NAME <u>Anna F. Damer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>012-01-2201</u>	
17. INFORMANT <u>Mary A. Trinkaus</u>		Address <u>5702 Edmondson Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer Breast</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Apr 1</u> , 19 <u>48</u> , to <u>4/23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/23/58</u> , 19 <u>58</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C J Mendelis</u> M.D.		ADDRESS (Street, city or town, state) <u>651 N Bentall St Baltimore Md</u>	
DATE SIGNED <u>5/23/58</u>			
PHYSICIAN'S NAME (Type) <u>C J Mendelis</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 26-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Geufel</u>		ADDRESS <u>5311 Edmondson Ave</u>	
24a. REC'D BY REGISTRAR <u>MR 24 58</u>		DATE	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH



BUREAU V. S.

APR 24 1958

RECEIVED

4375

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 2237 Reisterstown Rd	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VASELIOS Middle TSIMBIDES Last		4. DATE OF DEATH Month April Day 6 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-34
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMAN		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) GREECE
12. CITIZEN OF WHAT COUNTRY? GREECE ✓			
13. FATHER'S NAME A. TSIMBIDES		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 002X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-10-1957 to 4-6-1958 , that I last saw the deceased alive on 4-6-1958 , and that death occurred at Mt. Wilson, Maryland , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William Newcomer M.D.		Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-9-58	
22c. NAME OF CEMETERY OR CREMATORY Greek Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE APR 9 '58	
		24b. REGISTRAR'S SIGNATURE W. Search	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 9 1958

RECEIVED

4376 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b 28 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11111 Reisterstown Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Viola M Turnbaugh				4. DATE OF DEATH Month April Day 3 Year 19 58			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18 1910		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME D Fred Sprinkle				14. MOTHER'S MAIDEN NAME Ida V Walter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-32-7169		17. INFORMANT Mrs Frances Cole Address Reisterstown Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Congestive Heart Failure DUE TO (b) Rheumatic Heart Disease DUE TO (c) Hypertensive C V Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 2 years 2 years 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 15 , 1956, to April 3 , 1958, that I last saw the deceased alive on March 28 , 1958, and that death occurred at 1:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Clarence E. McWilliams M.D.				ADDRESS (Street, city or town, state) Reisterstown Maryland DATE SIGNED April 4 1958			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 5 1958		22c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery		22d. LOCATION (City, town, or county) (State) Arcadia Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Berryman & Sons				ADDRESS Reisterstown Md		24a. REC'D BY REGISTRAR DATE APR 7 '58	
				24b. REGISTRAR'S SIGNATURE Alb...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seneca Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seneca Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 534 Seneca Park</u>				d. STREET ADDRESS <u>Box 534 Seneca Park</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary G. Unverzagt</u>				4. DATE OF DEATH Month Day Year <u>April 8 19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 26, 1910</u>	
9. AGE (In years last birthday) <u>47 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William N. Hildebrand</u>				14. MOTHER'S MAIDEN NAME <u>Kantherine Kreiner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs George J. Linz</u>		Address <u>4628 Pimlico Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Heart</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Baltimore</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M.B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M.B. Davis M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 12, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook- Blight Inc.</u>				ADDRESS <u>6009 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 10 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>O. W. Leach</u>		DATE SIGNED <u>4/9/58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial. Cremation or removal.

BUREAU V. S.

APR 11 1958

RECEIVED

4378 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1619 E. Madison St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John		First NMI		Middle VESSEL		Last	
4. DATE OF DEATH April		Month 12		Day 19		Year 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1895	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Chemical Co.		11. BIRTHPLACE (State or foreign country) Lancaster Co, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Vessel		14. MOTHER'S MAIDEN NAME Pricilla Richards					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.1 METASTATIC CARCINOMA CERVICAL REGION, PLURA MEDIA STIMAL LYMPH NODES AND LIVER. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PRIMARY SQUAMOUS CARCINOMA, INFRA-ARBITAL REGION, RIGHT.						INTERVAL BETWEEN ONSET AND DEATH 1 Year 7 Months.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X BRONCHIAL PNEUMONIA, BILATERAL.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from April 2, 1958 to April 12, 1958 and that death occurred on 11:27 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE Chien Wei Lan		M.D. Veterans Administration Hospital		ADDRESS (Street, city or town, state) 4/12/58		DATE SIGNED	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-16-58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Frederick Rd., Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law		ADDRESS 802 Madison Ave.		24a. REC'D BY REGISTRAR APR 15 58		24b. REGISTRAR'S SIGNATURE Charles R. Law	

Charles R. Law, 802-04 Madison Ave., Balto., Md. APR 15 58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1933 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN 15 1888	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MARYLAND		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE	
APR 10 1933		BALTIMORE, MARYLAND		10:30 AM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

APR 15 1933

RECEIVED

4379

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Trailer Village</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Trailer Village</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Lodge Forest Nursing Home</i>				d. STREET ADDRESS <i>41 Dahlia Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Margaret</i> Middle <i>Wagner</i> Last <i></i>				4. DATE OF DEATH Month <i>Apr.</i> Day <i>24</i> Year <i>1958</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr. 28, 1887</i>	
9. AGE (in years last birthday) <i>70</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Henry Wagner</i>			
14. MOTHER'S MAIDEN NAME <i>Clara Watton</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Mr. Philip Wagner, 466 Carvall Beech Rd.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uncomplicated Circumstances</i> <i>196.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Malignant tumor of spine</i> DUE TO (c) <i></i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i> <i>3 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Aug. 29, 1955</i> to <i>Apr. 24, 1958</i> , that I last saw the deceased alive on <i>Apr. 24, 1958</i> , and that death occurred at <i>11:30 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>James T. Means</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>520 D St. Balto. Md. 4/26/58</i>			
PHYSICIAN'S NAME (Type) <i>James T. Means</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/28/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>1 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>Dee Schuch</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4380

CERTIFICATE OF DEATH

04369

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
14 Months				Owings Mill Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home				d. STREET ADDRESS R. F. D. # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lula Middle M. Last Wagoner				4. DATE OF DEATH Month 4 Day 15 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 16" 1885	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Secretary			10b. KIND OF BUSINESS OR INDUSTRY Cemetery Company Pleasant Hill, Md.		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John A. Dwyer				14. MOTHER'S MAIDEN NAME Jemina Handy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-10-4417		17. INFORMANT Mrs Gene Fuller Belhaven Beach Pasadena, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, ascending colon, with metastasis 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic hypertension CVD							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 1957, to April 9 , 1958, that I last saw the deceased alive on April 9 , 1958, and that death occurred at 3:04 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert J. Levickas M.D.				ADDRESS (Street, city or town, state) 2436 Washington Blvd. Baltimore 30, Md		DATE SIGNED 4/15/58	
PHYSICIAN'S NAME (Type) Herbert J. Levickas							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 18 1958		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ellis Ramoreau				24a. REC'D BY REGISTRAR APR 18 '58		24b. REGISTRAR'S SIGNATURE Alb...	

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4381

CERTIFICATE OF DEATH

04370

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cumberland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u>		d. STREET ADDRESS <u>340 William Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Agnes</u> Last <u>Weber</u>		4. DATE OF DEATH <u>Apr. 12, 1958</u> Day Year 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/5/1881</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Adam Weber</u>		14. MOTHER'S MAIDEN NAME <u>Susanna Laing</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Lung</u> 153.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Descending Colon</u> DUE TO (c) <u>1 1/2 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 19, 1956</u> to <u>April 12, 1958</u> , that I last saw the deceased alive on <u>April 11, 1958</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>2501 York St. - Towson Md.</u> <u>4/12/58</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-14-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Peters and Pauls</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>SCARPELLI FUNERAL HOME CUMBERLAND MD.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>APR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arden</u>	

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Date of Birth, Date of Death, Place of Death, Cause of Death, and other medical details. Includes a section for Hospital Records.

BUREAU V. S.

APR 14 1958

RECEIVED

Cum gratia No.

to Peters and Pauls

April 14-58

SCARFOLD FUNERAL HOME, CUM GRATIA NO.

CERTIFICATE OF DEATH

Reg. Dist. No.

04371

4332

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Balti.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>REISTERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>REISTERSTOWN, MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>24 BOND AVE.</u>		d. STREET ADDRESS <u>124 BOND AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MURRAY</u> Middle <u>M.</u> Last <u>WELCH</u>		4. DATE OF DEATH Month <u>APR.</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 15, 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHIPWRIGHT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COAST GUARD</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN T. WELCH</u>		14. MOTHER'S MAIDEN NAME <u>HENRIETTA MADDEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>MRS. MARY E. WELCH</u>	
17. ADDRESS <u>24 BOND AVE. REISTERSTOWN, MD.</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>6 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 8, 1948 to 11-11, 1958, that I last saw the deceased alive on 4-14, 1958, and that death occurred at 6:30 a. m. from the causes and on the date stated above.

ACTUAL SIGNATURE <u>Martin E. Strobel</u>	M.D. <u>48 Main St. Reisterstown Md.</u>	DATE SIGNED <u>4/19/58</u>
PHYSICIAN'S NAME (Type) <u>Martin E. Strobel M.D.</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APR. 23, '58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. LUKE</u>	22d. LOCATION (City, town, or county) (State) <u>REISTERSTOWN, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home</u>		24a. REC'D BY REGISTRAR <u>1631 David Hill Ave.</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred</u>
DATE <u>APR 22 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4322

BUREAU X. F.

APR 22 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 14 Film G228 5-12-58 et

CERTIFICATE OF DEATH

04372

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 39 Waterview Rd.		d. STREET ADDRESS 39 Waterview Rd.	
3. NAME OF DECEASED (Type or print) First SOPHIA Middle WERNER Last WERNER		4. DATE OF DEATH Month April Day 7 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1887.
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months 7 Days 1 Hours 15 Min.	IF UNDER 24 HRS. Months 7 Days 1 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY At Home.	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Doyle		14. MOTHER'S MAIDEN NAME Mary (Last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John A. Werner		Address Same.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Coronary arteriosclerosis DUE TO (c) Coronary arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Immediate 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of larynx		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1958 to March 1958 , that I last saw the deceased alive on March 1958 , and that death occurred at 5:45 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE B.W. Solod		DATE SIGNED 2900 DUNRAN RD 4-8-58	
PHYSICIAN'S NAME (Type) B.W. SOLLOD, M.D.		Dundalk-22-201	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-10-58.	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn CEM.		22d. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Seiler		ADDRESS 9015 CONKLING ST. BALTO, MD.	
24a. REC'D BY REGISTRAR APR 10 58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

CERTIFICATE OF DEATH

Form No. 100

RECEIVED
APR 11 1958
BUREAU V. S.

11-1-57

Form with multiple sections for death certificate, including fields for name, date, cause of death, and signature.

NOV 1957

RECEIVED
APR 11 1958
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04373

Reg. Dist. No.

4383

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoneleigh		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stoneleigh	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 120 Dumbarton Road.		d. STREET ADDRESS 120 Dumbarton Road.	
3. NAME OF DECEASED (Type or print) First JAMES Middle J. Last WHELAN IV		4. DATE OF DEATH Month April Day 27 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 15, 1957
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME James J. Whelan, 3rd		14. MOTHER'S MAIDEN NAME Phyllis R. Reymann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Parents	
17. INFORMANT same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis and Minimal Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 525x DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/28/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/29.58	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR W. J. Ruck	
ADDRESS 5305 Harford Road #14		DATE MAY 1 '58	

2037221XV5

4384 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Freeland</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Freeland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Oakland Rd.</i>		d. STREET ADDRESS <i>1 Oakland Rd.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>William Robert Whipperman</i>		4. DATE OF DEATH Month <i>April</i> Day <i>8</i> Year <i>1958</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 4, 1886</i>
9. AGE (In years last birthday) <i>72</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Beckleysville, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Hammond Whipperman</i>		14. MOTHER'S MAIDEN NAME <i>Rose Marvil</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>219-36-1247</i>	
17. INFORMANT <i>Mr. Lida Whipperman</i>		Address <i>Freeland Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Cardid-Vascular Disease</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Vascular Accident</i> <i>2 yrs</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3-9-</i> , 19 <i>55</i> , to <i>4-8-</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Apr. 3</i> , 19 <i>58</i> , and that death occurred at <i>3:40 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul D. Shaub</i>		ADDRESS (Street, city or town, state) <i>Shrewsbury, Pa.</i>	
PHYSICIAN'S NAME (Type) <i>Paul D. Shaub</i>		DATE SIGNED <i>Apr 14 '58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/12/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Freedom Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>New Freedom, Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Isaac Rostenberg</i>		ADDRESS <i>New Freedom, Pa.</i>	
24a. REC'D BY REGISTRAR <i>Alfred</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred</i>	
DATE <i>APR 14 '58</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1000

8261 77 88

8367

4385 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 Prospect Ave.		d. STREET ADDRESS 2 Prospect Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle T. Last Williams		4. DATE OF DEATH Month April Day 13 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1893
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tavern Keeper		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George A. Williams		14. MOTHER'S MAIDEN NAME Fannie Wallace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Edith M. Williams, Glyndon, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emphysema 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 9-15-38 , 19____, to 4-13-58 , 19____, that I last saw the deceased alive on 4-13-58 , 19____, and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 4-14-58			
ACTUAL SIGNATURE D. D. Caples		M.D. 6 Hanover Rd.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 16/58	22c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery	22d. LOCATION (City, town, or county) (State) Reisterstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE APR 16 '58	
		24b. REGISTRAR'S SIGNATURE Dee Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 16 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4386 CERTIFICATE OF DEATH

04376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>19</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>in</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt.</u>		c. LENGTH OF STAY IN 1b <u>10 weeks</u>	
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2300 Lodge Forest hwy</u>		d. STREET ADDRESS <u>#1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY</u> <u>IDA</u> <u>WILSON</u>		4. DATE OF DEATH Month Day Year <u>APR</u> <u>26</u> <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 26. 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NOAH FOX</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Jenkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ethel Jones</u>		Address <u>- address as in #1.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno carcinoma - pulmonary</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 13</u> , 19 <u>58</u> , to <u>April 26</u> , 19 <u>58</u> , that I lost saw the deceased alive on <u>April 25</u> , 19 <u>58</u> , and that death occurred at <u>4 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Tollin</u>		DATE SIGNED <u>6908 N. POINT RD.</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN</u>		<u>BALTO-19-MD</u> <u>4/26/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/29/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO.</u> <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Connelly</u>		ADDRESS <u>Essex, 21 md.</u>	
24a. REC'D BY REGISTRAR <u>APR 30 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Deed</u>	

BUREAU A. S.

APR 30 1958

RECEIVED

4212 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto Highlands</u>		c. LENGTH OF STAY IN 1b <u>Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Highlands</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2900 Vermont Ave</u>				d. STREET ADDRESS <u>2900 Vermont Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherina</u> Middle <u>Winter</u> Last <u>Winter</u>				4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 30, 1974</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob STRICKER</u>				14. MOTHER'S MAIDEN NAME <u>Maie Purple</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, right</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-29</u> , 19 <u>49</u> , to <u>4-5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4-5</u> , 19 <u>58</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1227 Washington Blvd.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>John P. Unbeck Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-9-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon PK Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mc Call Funeral Home</u>				ADDRESS <u>1305 Fort Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

APR 9 1958

RECEIVED

4387 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 11yr17dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING G ROVE STATE HOSPITAL				e. STREET ADDRESS Upper Marlboro, Md.			
3. NAME OF DECEASED (Type or print) Rose Kuhn Wise				4. DATE OF DEATH Month April Day 14 Year 19 58			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1888		9. AGE (In years lost birthday) yrs. 69	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Kuhn				14. MOTHER'S MAIDEN NAME Mary A. Wiseman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X Pneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from April 12 , 19 58 to April 14 , 19 58 that I last saw the deceased alive on April 14 , 19 58 , and that death occurred at 5:30aM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL		DATE SIGNED 4-14-58	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-17-58		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE APR 15 '58		24b. REGISTRAR'S SIGNATURE Cliff Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. 2

APR 15 1958

RECEIVED

4388 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>25 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>(Served as) CHARLES</u> Middle <u>WOLF</u> Last <u>WOLFE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 25, 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garbage dumps</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Silas Wolfe</u>		14. MOTHER'S MAIDEN NAME <u>Ella Chaney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>219-01-9163</u>	
17. INFORMANT <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>162.1</u> IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA, LEFT LUNG, WITH METASTASIS TO RIGHT LUNG, LIVER, INTESTINES, RIBS AND LYMPH NODES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UNKNOWN</u> (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Operation - Thoracotomy, left, with left upper lobectomy, 4/30/57</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 26</u> , 19 <u>58</u> , to <u>April 20</u> , 19 <u>58</u> , that I last saw the deceased <u>alive on</u> <u>5:07 PM</u> , and that death occurred at <u>5:07 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chien Wei Lan</u>		ADDRESS (Street, city or town, state) <u>VAH, FORT HOWARD, MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u>CHIEN WEI LAN, M.D.</u>		DATE SIGNED <u>4/21/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-24-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u>		ADDRESS <u>6009 Harford Rd., Baltimore, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Cook-Blight</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

PAID BOND

BUREAU V. S.

APR 23 1950

RECEIVED

4389 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 CATONSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 748 CHARING CROSS		d. STREET ADDRESS 1748 CHARING CROSS	
3. NAME OF DECEASED (Type or print) ANNA G. WOODS		4. DATE OF DEATH APR. 29 1958	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 29, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	
11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GERLACH		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. MRS CATHERINE A. WILSON	
17. INFORMANT 748 CHARING CROSS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: Acute myocardial insufficiency IMMEDIATE CAUSE (a) 443X DUE TO Hypertensive arteriosclerotic cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) disease DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 4, 19 47 to April 29 , 19 58 , that I last saw the deceased alive on April 29 , 19 58 , and that death occurred at 9:45 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George A. Knipp		ADDRESS (Street, city or town, state) 4116 Edmondson Avenue	
PHYSICIAN'S NAME (Type) George A. Knipp, M. D.		DATE SIGNED Apr. 29, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/2/58	
22c. NAME OF CEMETERY OR CREMATORY PARKWOOD		22d. LOCATION (City, town, or county) (State) BALTO, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WITZKE FUNERAL DIR.		24a. REC'D BY REGISTRAR ALF	
ADDRESS 4101 EDMONDSON		24b. REGISTRAR'S SIGNATURE W. Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4390 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>824 Northern Pky</u> b. COUNTY <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Villa Nova</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Robb Nursing Home</u>		d. STREET ADDRESS <u>824 Northern Parkway</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E</u> Last <u>Wooten</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-19-73</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Emory Poulton</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Vromwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Katherine Robb</u>		Address <u>4105 Essex Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemiplegia CVA</u> (c) <u>Arteriosclerotic C.V.D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>?</u> <u>7</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>13 April</u> , 19 <u>58</u> , to <u>13 April</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>13 April</u> , 19 <u>58</u> , and that death occurred at <u>6:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Williams</u>		ADDRESS (Street, city or town, state) <u>1632 Reisterstown Rd.</u> DATE SIGNED <u>13 April 58</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>		<u>Pikesville 8, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 16, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons Inc.</u>		ADDRESS <u>1900 Eutaw Place</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>	

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CERTIFICATE OF DEATH

Form No. 10

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES HENRY POWELL		MALE		35		JAN 15 1898		LONDON ENGLAND	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
APR 15 1939		LONDON ENGLAND		HEART DISEASE		NATURAL		LABORER	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FAMILY SIZE	
JAMES HENRY POWELL		CATHERINE POWELL		LABORER		LABORER		5	
EDUCATION		RELIGION		MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE REGISTERED	
SCHOOL		METHODIST		1915		LONDON ENGLAND		YES	
PREVIOUS MARRIAGES		PREVIOUS DEATHS		PREVIOUS MARRIAGES		PREVIOUS DEATHS		PREVIOUS MARRIAGES	
NONE		NONE		NONE		NONE		NONE	
PREVIOUS MARRIAGES		PREVIOUS DEATHS		PREVIOUS MARRIAGES		PREVIOUS DEATHS		PREVIOUS MARRIAGES	
NONE		NONE		NONE		NONE		NONE	
PREVIOUS MARRIAGES		PREVIOUS DEATHS		PREVIOUS MARRIAGES		PREVIOUS DEATHS		PREVIOUS MARRIAGES	
NONE		NONE		NONE		NONE		NONE	

BUREAU V. 2

APR 15 1939

RECEIVED

4391 CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH o. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
3. NAME OF DECEASED (Type or print) HARVEY First ELWOOD Middle ZIMMERMAN Last		9. DATE OF DEATH Month 4 Day 15 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-06
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIPPING CLERK		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME E. VERNON ZIMMERMAN		14. MOTHER'S MAIDEN NAME ROSIE MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-05-7953	
17. INFORMANT Hospital Records		Address Mt. Wilson State Hosp.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MODERATELY ADVANCED PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 002X DUE TO (c) 2 years INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMPHYSEMA, ASTHMA BRONCHIALIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 1-29 19 58 , to 4-15 19 58 , that I last saw the deceased alive on 4-15 19 58 , and that death occurred at 2 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE William Newcomer M.D. Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) William Newcomer, M.D. Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/18/1958	22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	22d. LOCATION (City, town, or county) (State) Randallstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ELLSWORTH ARMAGOST Paul L. Sturm		24a. REC'D BY REGISTRAR APR 21 58 DATE	24b. REGISTRAR'S SIGNATURE West

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.
APR 21 1958

RECEIVED